Governor's Council on Substance Abuse

Survey of Policies and Procedures for Drug-Endangered Children in Washington State

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STATE OF WASHINGTON
DEPARTMENT OF COMMUNITY, TRADE AND ECONOMIC DEVELOPMENT

September 14, 2006

The Honorable Christine Gregoire
Governor, State of Washington
Legislative Building
Post Office Box 40002
Olympia, Washington 98504-0002

Dear Governor Gregoire:

On behalf of the Governor's Council on Substance Abuse I am pleased to transmit to you the results of a study of protocols for drug-endangered children conducted by Council staff and staff from the Administrative Office of the Courts.

This study of local procedures for handling drug-endangered children was conducted during 2005 and 2006 to help the Council better understand how communities within Washington State are coping with the need to provide substance abuse intervention that addresses the needs of drug-endangered children (DEC).

Concerns about the impact of methamphetamine (meth) abuse in Washington State began in the early 1990s. Throughout the 1990s and into the 2000s the rates for meth-related crime, drug treatment admissions, and environmental contamination continued to climb. Recent legislation regulating precursor chemicals, and focused enforcement strategies combined with collaborative community efforts, have significantly impacted local meth production.

Compared to past drug epidemics, what seemed different about methamphetamine was the simultaneous impacts on systems that had not traditionally worked together on joint drug abuse reduction strategies. This included law enforcement, chemical dependency treatment providers, health departments, ecology, schools, child welfare agencies, landlords, and retail stores selling over-the-counter cold remedies.

The Council has been concerned about the growing correlation between the use of methamphetamine and increased incidents of domestic violence, assault, property crimes, identity theft, burglary, fraud**,** child abuse and neglect, and the propagation of HIV/AIDS and sexually transmitted diseases.

Of particular concern to the Council is the fate of children and youth who have become innocent victims of this terrible drug through the inability of their meth-addicted parents or guardians to properly protect them and provide for their basic needs.

Child meth-related dangers come from both direct exposures to toxic chemicals present at meth manufacturing sites, as well as abuse and neglect issues arising from having parents on meth.

In response to the needs of children impacted by meth, the Washington State Governor's Meth Coordinating Committee developed a guideline for handling drug-endangered children, Washington's Endangered Children's Assessment and Response, or "We Care."[1] It provides for collaboration between law enforcement, the state's child protective services, local prosecution, and local medical providers. These entities need to communicate with each other and coordinate their responses to the immediate needs of meth-endangered children.

In its 2005-07 Biennial Recommendations for State Policy Action, the Governor's Council on Substance Abuse gave its support to implementation of the We Care guidelines for Drug-Endangered Children. The Council recommended that the matrix be used as a guide to facilitate the development of response protocols for law enforcement, prosecutors, child protective services, and medical providers to address situations where there is reasonable cause to believe that abuse and neglect of a child has occurred due to the parent's or guardian's addiction to controlled substances, or due to the child's direct exposure to chemicals and processes involved in the manufacture of illegal drugs.

The Governor's Council on Substance Abuse recognizes that each county and community impacted by meth is unique and may have differences in its needs and available resources that will influence the type of response and procedures for drug-endangered children that are implemented.

This study surveyed the status of local DEC procedures in Washington State. The purpose of this study was to identify local procedures—whether formal or informal—for handling drug-endangered children, and to compare these procedures to the steps recommended by the We Care matrix.

In the course of developing the survey other research questions emerged, including whether DEC procedures differ when a child is drug-endangered through parental abuse or neglect versus when a child is endangered through direct exposure to a drug or associated toxic chemicals. Additionally, this study explored whether counties have different procedures when a child is endangered by a drug other than meth, such as other illicit drugs, alcohol, or prescription drugs.

[1] Washington State Governor's Meth Coordinating Council. *We Care: Recommended Best Practices Addressing the Needs of Drug Endangered Children*. August 2004.

We hope the results of this study on protocols for drug-endangered children will be of assistance for forming a more complete picture for how cross system approaches are being implemented to provide a safety net for children at risk of child abuse and neglect due to the drug abuse of their parents or guardians. Please contact me or Council staff if you would like additional information about this study.

Sincerely,

Priscilla Lisicich, Ph.D, Chair
Governor's Council on Substance Abuse

cc: John Lane
Council Members

The points of view or opinions expressed by the Governor's Council on Substance Abuse do not necessarily represent the official position of the Governor's Office, the Department of Community, Trade and Economic Development, or other participating agencies.

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Mariann Whalen, Vice Chair, Governor's Council on Substance Abuse

Thank you to all the people from law enforcement agencies, Child Protective Services, medical services and county prosecutors from around the state who responded to our survey and shared the local protocols and procedures being used to ensure that the needs of drug-endangered children are being met.

A special thanks to the Community Mobilization Against Substance Abuse and Violence coordinators in Washington's 39 counties, whose efforts to gather survey responses from programs in their counties made the survey possible.

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EXECUTIVE SUMMARY

This study of local procedures for handling drug-endangered children was conducted during 2005 and 2006 at the request of the Governor's Council on Substance Abuse (Council). The Council wanted an improved understanding of how communities in Washington State are coping with the need to provide substance abuse intervention that addresses the needs of drug-endangered children (DEC). This report is the result of that request.

Concerns about the impact of methamphetamine (meth) abuse in Washington State began in the early 1990s. Throughout the 1990s and into the 2000s the rates for meth-related crime, drug treatment admissions, and environmental contamination continued to climb. Recent legislation regulating precursor chemicals, and focused enforcement strategies combined with collaborative community efforts, have significantly impacted local meth production.

Meth abuse affects multiple systems—such as law enforcement, chemical dependency treatment providers, health departments, ecology, schools, child welfare agencies, landlords, and retail stores selling over-the-counter cold remedies—that have not traditionally worked on joint drug abuse reduction strategies.

Meth abuse is correlated with many other crimes, including increased incidents of domestic violence, assault, property crimes, identity theft, burglary, fraud**,** and child abuse and neglect. It has also been associated with the propagation of HIV/AIDS and other sexually transmitted diseases.

Children and youth become innocent victims of this terrible drug through the inability of their meth-addicted parents or guardians to properly protect them and provide for their basic needs. Other meth-related dangers to children come from direct exposure to toxic chemicals present at meth manufacturing sites, and from abuse tied to parents' meth use.

The Washington State Governor's Meth Coordinating Committee developed guidelines for handling drug-endangered children, Washington's Endangered Children's Assessment and Response, or "We Care."[2] It calls for a collaborative response by law enforcement, the state's Child Protective Services, local prosecution, and local medical providers.

In its 2005-07 Biennial Recommendations for State Policy Action, the Council recommended that the We Care Matrix be used to guide development of local response protocols. The protocols would address situations where there is reasonable cause to believe that abuse and neglect of a child has occurred due to the parent's or guardian's addiction to controlled substances, or due to the child's direct exposure to chemicals and processes involved in the manufacture of illegal drugs.

[2] Washington State Governor's Meth Coordinating Council. *We Care: Recommended Best Practices Addressing the Needs of Drug Endangered Children*. August 2004.

The Council recognizes that each county and community impacted by meth is unique and may have differences in its needs and available resources that will influence the type of response and procedures for drug-endangered children that are implemented.

The present study surveys the status of local DEC procedures in Washington State, whether formal or informal, and compares them to the We Care Matrix recommendations. A distinction is made between DEC procedures for a child drug-endangered through parental abuse or neglect versus a child endangered through direct exposure to a drug or associated toxic chemicals. Additionally, this study explored whether counties have different procedures when a child is endangered by a drug other than meth, such as other illicit drugs, alcohol, or prescription drugs.

It is important to note that this study asks what procedures are in place, but does not ask why particular procedures are used, how frequently they are needed, or how consistently they are implemented. These are topics for future research. The following report is only an inventory of what is currently in place in areas served by the respondents. It is hoped this inventory will facilitate information sharing and identification of existing resources.

Method

The survey follows the components of the We Care Matrix, assessing the existence of local protocols for drug-endangered children across four DEC-impacted systems:

- Law Enforcement
- Child Protective Services
- Medical Services
- Prosecutor

Survey Instrument

Four surveys were developed, one tailored to each system. Community Mobilization coordinators in the 39 counties were asked to identify a county representative for each of these four systems to respond to the survey. In interpreting the results, it is important to note that the combination of matrix category, agency, and job position of the respondent determine how much of the county is represented in the survey response. For example, there was only one law enforcement respondent for each county, even though each county has multiple law enforcement agencies (sheriff and police); in addition, a survey respondent's knowledge could be limited to activities in his or her unit.

"Drug-endangered children" was defined as:

"1. Children who there is reason to believe have been **abused or neglected** by the adult (a parent or another adult) responsible for their care due to that adult's abuse of alcohol or controlled substances; or

"2. Children who are at risk because they are being **directly exposed** to alcohol, illicit drugs, or illegal drug manufacturing activities."

Respondents were asked to indicate whether their agency has procedures in place for each component identified in the matrix for their field. Respondents were instructed to answer "yes" if they have a formal or informal procedure, regardless of how frequently they might have cause to use the procedure.

Results

Respondent Characteristics

Thirty-two of the 39 counties (82 percent) in Washington State responded to the survey. For comparison purposes, counties were divided based on population size into small (population less than 45,000), medium (population greater than 45,000 and less than150,000), and large (population greater than 150,000) counties. Responding counties, classified by population size, were as follows:

Overall = 32 out of 39 (82%)

- Small counties = 16 out of 18
- Medium counties = 8 out of 11
- Large counties = 8 out of 10

Surveys received for the four Matrix areas were as follows:

- Law enforcement = 29 out of 39 (74%)
- Child Protection Services = 28 out of 39 (72%)
- Medical = 27 out of 39 (69%)
- Prosecution = 24 out of 39 (62%)

Implementation of Matrix Procedures

Law Enforcement (LE)

Under the We Care Matrix, law enforcement's role is to assess the condition of the child, place the child in protective custody, and collect physical evidence.

A majority of responding law enforcement agencies reported having DEC procedures for the following:

- Taking a child into protective custody
- Transferring custody to Child Protective Services
- Documenting evidence of various kinds (environmental dangers, child care conditions)

In general, less than half of law enforcement respondents reported having DEC procedures for the following:

- Collecting biological samples

- Submitting biological samples to a lab

In terms of type of drug, DEC procedures were most common for meth cases, whether for child abuse/neglect or direct exposure to toxic chemicals. Law enforcement agencies reported having DEC procedures for meth more often than for other drugs on almost every question. DEC procedures for alcohol were least common.

Child Protective Services

Under the We Care Matrix, Child Protective Service's role is to accept transfer of custody of the drug-endangered child from law enforcement; to coordinate urine sample collection; to arrange for decontamination of the child; to conduct the initial interview with the child; to transport the child to the appropriate facility; to conduct a placement assessment; and, after the court makes a placement determination, to ensure a continuum of care for the child.

Over 80 percent of respondents have procedures for initial child interview and placement assessment.

Over 50 percent of respondents reported that Child Protective Services is responsible for decontamination and transporting children for meth cases. Medium and small counties were more likely than large counties to have procedures that provide a uniform response for drugs other than meth. Most counties reported fewer procedures for responding to abuse and neglect situations associated with other drugs.

Medical Services

Medical responsibilities under the matrix include conducting a timely medical exam, collecting a urine sample within four hours, conducting an Early Periodic Screening, Detection, and Treatment (EPSDT) exam within one month of placement, and conducting follow-up exams as needed. It is worth noting that the necessity and value of urine collection is a matter of debate in the criminal justice and medical community.

Medical provider respondents reported having procedures in place for meth-related DEC cases more often than for cases involving other drugs, for every type of procedure asked about in the DEC survey. Examples of procedures that were more common for meth than for other drugs include:

- Conducting a medical exam within 24 hours if illness is suspected.
- Conducting a medical exam within 7 to 14 days if illness is not apparent.
- Collecting biological samples.

Out of all medical procedures, conducting a medical exam within 24 hours was the most prevalent procedure, with 67 to 73 percent of medical respondents having such a procedure for meth DEC cases (41 percent to 46 percent had a similar procedure for other types of drugs).

Medical providers without DEC procedures commented that cases are treated on a case-by-case basis.

About half of the medical provider respondents send biological samples to the state lab for meth cases. The Washington State Patrol (WSP) toxicology lab tests for lower concentrations of drugs than is typical for hospital labs, which can be important from an evidentiary standpoint.

Prosecutor

Under the We Care Matrix, the prosecutor's role is to review the evidence and decide whether criminal child endangerment charges should be filed.

Fewer prosecutor's offices (27 percent to 50 percent) reported that they have a procedure to consider a case's implications for drug-endangered children and to consider what legal action may best protect the children's interests. Instead, many offices handle cases on a case-by-case basis, not unlike many medical providers.

Some findings include:

- Type of drug: Specific DEC procedures were least likely to exist for alcohol.
- Type of case: Specific DEC procedures were less likely to exist for custody-related cases than for criminal or child endangerment cases.
- Child endangerment: Less than a third of responding counties (29 percent) had charged any cases under the child endangerment laws for methamphetamine manufacture (RCW 9A.42.100).
- Exceptional sentences: Slightly fewer than half of responding counties (43 percent) had sought increased or exceptional sentences based on presence or exposure of children in drug cases. The frequency with which offices had sought sentencing increases ranged from routine to rare.

Meth versus Other Drugs

Do agencies perceive a greater problem with meth-related DEC as opposed to children endangered by other drugs? In many counties the answer was "yes." Of the four agency types, law enforcement and medical providers tended to have a greater percentage of counties whose procedures distinguish between meth and other drugs, especially in the larger counties. In counties that distinguished between meth and other drugs, meth was perceived as having potentially more immediately dangerous consequences (toxicity from labs, etc.).

In only about a third of the counties did Child Protective Services and prosecutor's offices have procedures that distinguish between meth and other drugs, with larger counties being among the least likely to make such a distinction.

Meth (Abused) versus Meth (Exposed)

When counties have DEC procedures for children's direct exposure to meth, they also tend to have procedures for child abuse arising from meth use. However, child abuse and direct exposure raise different concerns, which may be addressed by different procedures.

Based on a review of protocols and open-ended comments from survey respondents, it appears that in criminal cases law enforcement is more likely to lead the investigation. For child welfare cases Child Protective Services is more likely to take the lead.

County resources may play a role in whether agency procedures for abuse and neglect differ from procedures for direct exposure. Some of the open-ended comments received from respondents indicate that with law enforcement, prosecutor's offices, and medical facilities, larger organizations may be able to fund specialized units that handle particular types of cases.

Conclusion

A majority of counties have at least some kind of protocol in place for handling drug-endangered children. Many protocols are meth-specific, whether the issue is abuse/neglect from a drug user or direct exposure to chemicals. Protocols for children endangered by other types of drugs exist but tend to be less common.

Some overall conclusions that can be drawn from the survey results include the following observations:

- More DEC protocols exist for meth than for other drugs.
- Law enforcement tends to take the lead for criminal cases; Child Protective Services takes the lead for child welfare investigations.
- Types of protocols vary widely:
  - Whether or not they follow the matrix
  - The number and range of collaborating agencies involved.
- Medical facilities tend to have general policies that include meth rather than having meth-specific protocols.
- Greater resources lead to a greater ability to address the specific needs of drug-endangered children.

<u>Protocol Characteristics</u>

Some counties follow the We Care Matrix closely, forming DEC protocols from the four matrix areas (law enforcement, Child Protective Services, medical facility, and the prosecutor's office). Other counties may have just one area with its own set of developed protocols that specify how it will interact with the other main players. Some counties take a broader approach than the matrix, soliciting collaboration from a broader range of players including the school district, health department, and community service agencies.

Future Research

This study is a first look at how meth-related child impacts are addressed versus other drugs in each county. It provides an overall picture of DEC protocols that have been implemented statewide.

From here, future studies can expand on the information gathered. Some potential avenues of further exploration include the following suggestions:

- Expand the matrix to include other agencies (Attorney General, courts, schools, community service organizations, foster care, etc.).
- Investigate the effectiveness of different models.
- Collect more data, including from more counties, more agencies within counties, and tribal nations.
- Conduct in-depth survey follow-up interviews and site visits.
- Explore long-term child impacts caused by placement decisions, court-based sentencing alternatives for parents, community wraparound services, etc.

This study has compiled a resource of existing DEC guidelines that can serve as resources for other counties (see Technical Appendix). These materials provide useful data that could be used for developing a set of Model Procedures that incorporates the best features of existing guidelines.

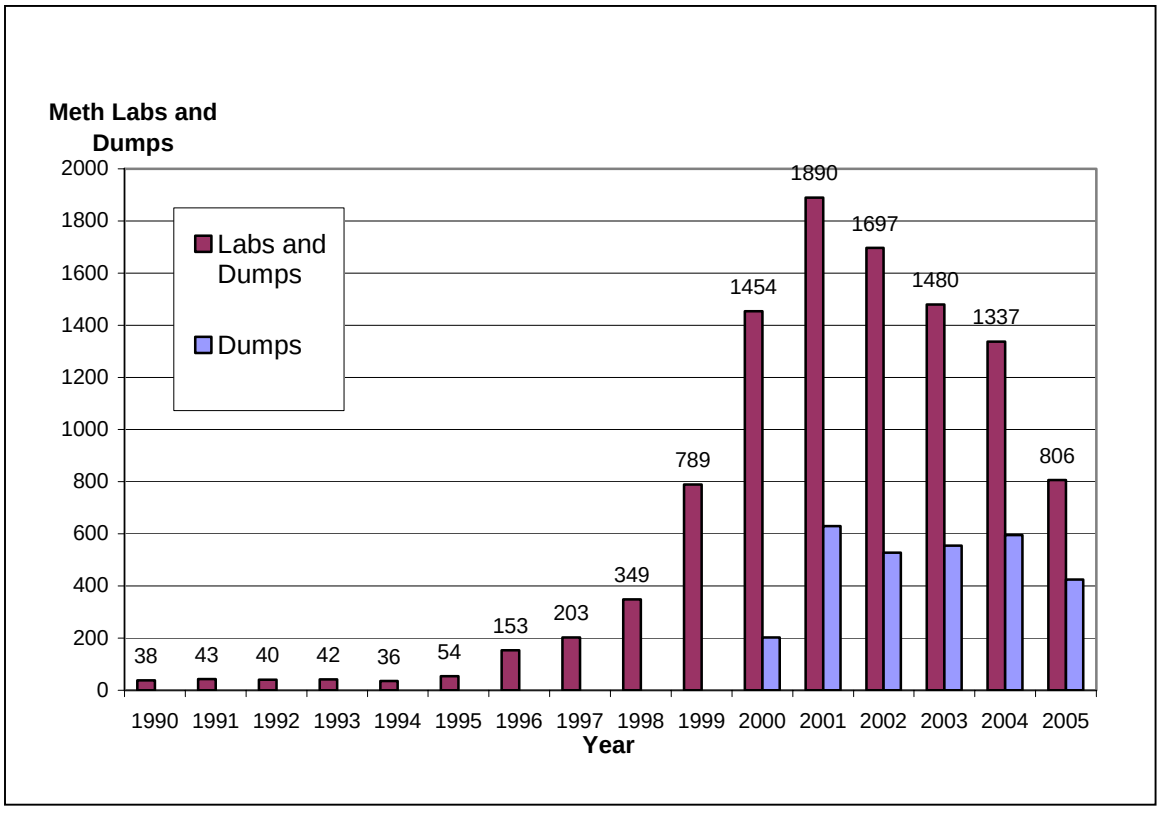
Survey of Policies and Procedures for Drug-Endangered Children in Washington State

INTRODUCTION

This study of local procedures for handling drug-endangered children was conducted during 2005 and 2006 at the request of the Governor's Council on Substance Abuse (Council). The Council wanted an improved understanding of how communities in Washington State are coping with the need to provide substance abuse intervention that addresses the needs of drug-endangered children. This report is the result of that request.

Concerns about the impact of methamphetamine (meth) abuse in Washington State began in the early 1990s. Throughout the 1990s and into the 2000s the rates for meth-related crime, drug treatment admissions, and environmental contamination continued to climb (see Figure 1). Recent legislation regulating precursor chemicals, and focused enforcement strategies combined with collaborative community efforts, have significantly impacted local meth production. By 2005 the numbers of meth labs and dump sites reported to the Department of Ecology had declined significantly.

Figure 1. Ecology-reported Meth Labs and Dump Sites (1990-2005)

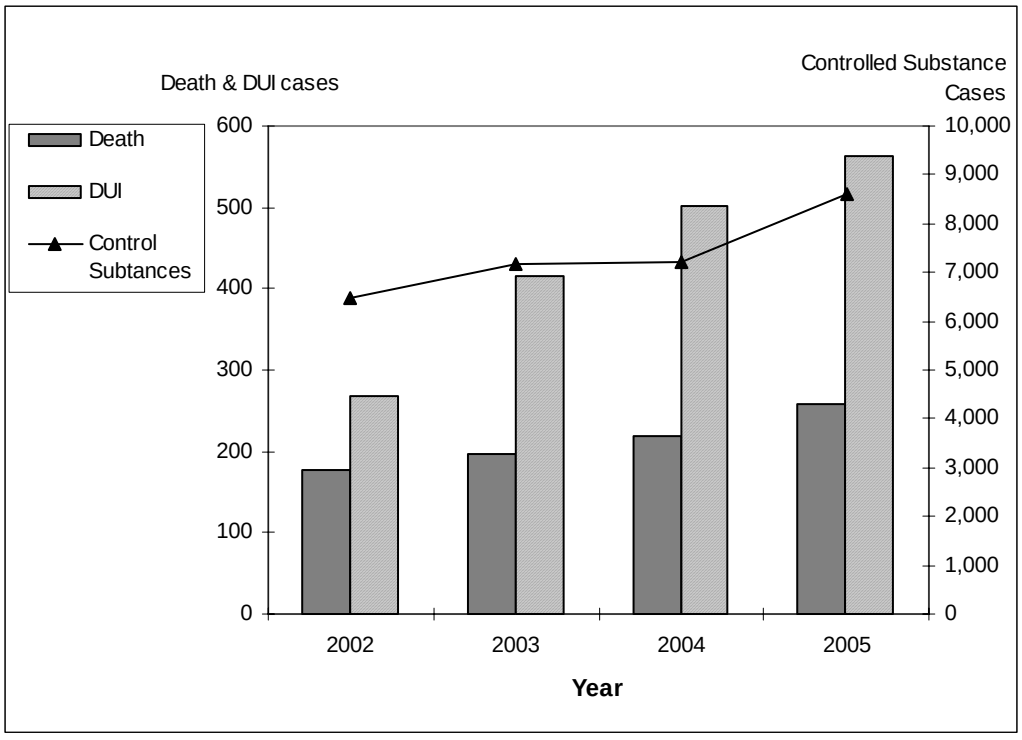


However, the numbers of meth-involved deaths, meth DUIs, toxicology cases where children 15 years of age and younger were meth positive, and meth-positive controlled substance abuse cases continued to climb significantly from 2002 to 2005 (see Table 1 and Figure 2 below).[3] These data support law enforcement intelligence reports that indicate that meth is now being imported into the state by traditional poly-drug trafficking organizations.

Table 1. State Toxicology Lab Methamphetamine Statistics

	2002	2003	2004	2005
Deaths - Meth involved	176	197	220	257
DUI - Meth	267	415	502	563
Toxicology cases - Meth positive in children 15 and younger	13	15	32	20
Control substance cases - Meth positive	6,467	7,179	7,207	8,620

Figure 2. Graphical Representation of State Toxicology Meth Statistics



Compared to past drug epidemics, what seemed different about methamphetamine was the simultaneous impacts on systems that had not traditionally engaged in joint drug abuse reduction strategies. This included law enforcement, chemical dependency

[2] Data provided by Washington State Patrol Toxicology Laboratory, 2006

treatment providers, health departments, ecology, schools, child welfare agencies, landlords, and retail stores selling over-the-counter cold remedies. For example:

- Law enforcement: The number of residential meth labs and dumps reported statewide increased from 38 in 1990 to 789 in 1999. That number peaked to a high of 1,715 labs and dump sites in 2001, and has since decreased to 719 in 2005.[4]
- Treatment providers: Admission to publicly-funded treatment programs rose from 486 (or nine per 100,000 population) in 1990 to 4,854 (or 84 per 100,000 population) in 1999. By 2004, the number of patients admitted for meth treatment in Washington State had risen to 6,863 (or 111 per 100,000 population). This pattern is consistent with continued availability of the drug in communities.[5]
- Schools: In a 1998 state survey, 11 percent of high school seniors reported that they had tried meth at least once. In 2004 out of 5,976 high school seniors surveyed, 6.3 percent reported trying meth at least once.[6]

The Governor's Council on Substance Abuse's 2000 report on meth recommended that:[7]

1. The Department of Community, Trade and Economic Development, through its Community Mobilization (CM) Program and the CM contractors in Washington's 39 counties, should form Meth Action Teams in local communities heavily impacted by meth.
2. State government should take action to provide a statewide meth public awareness and education program.
3. Community-based meth prevention models should be piloted to assess whether targeting meth use is more effective than generic substance abuse prevention models.
4. An aggressive program of training and technical assistance should be implemented for all public and private agencies, retailers, and other community organizations providing services related to meth impacts.

Since the 2000 meth study, the Governor's Council on Substance Abuse has remained concerned and involved with studying the impacts of methamphetamine in Washington State and has supported meth-related policy actions in each of its biennial

[4] Washington State Department of Ecology, 2006.

[5] Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State, 2005 Report*.

[6] Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, Department of Community, Trade and Economic Development, Family Policy Council. *Washington State Healthy Youth Survey 2004 Analytic Report*. Einspruch, RMC Research Corporation, June 2005.

[7] Governor's Council on Substance Abuse. *Methamphetamine Abuse in Washington State*, Lisicich and Owens, May 2000, p 1.

recommendations to the Governor and state agencies. The policy recommendations have been aimed at preventing future meth-related impacts, providing treatment for Washington residents addicted to meth, and assuring that there is an adequate law and justice system response to reduce the manufacturing and trafficking of meth and related criminal activities.

The Council is concerned about the growing correlation between the use of methamphetamine and increased incidents of domestic violence, assault, property crimes, identity theft, burglary, fraud**,** child abuse and neglect, and the propagation of HIV/AIDS and other sexually transmitted diseases.

Of particular concern to the Council is the fate of children and youth who have become innocent victims of this terrible drug through the inability of their meth-addicted parents or guardians to properly protect them and provide for their basic needs. Meth-related dangers to children come from direct exposure to toxic chemicals present at meth manufacturing sites, and from abuse tied to parents' meth use.

Direct Exposure and Other Lab Risks

Law enforcement officials find evidence of children present in at least a third of the clandestine labs seized in Washington State.[8] In 2000 out of approximately 1,254 labs, 238 children (19 percent) were found at clandestine labs in Washington State investigated by law enforcement agencies.

According to El Paso Intelligence Center (EPIC) National Clandestine Laboratory Seizure System (NCLSS) data, there were 1,660 children affected nationally by, injured, or killed at methamphetamine labs during calendar year 2005, including 11 injuries and two deaths. This number was down from 3,104 children affected nationally out of 17,170 labs, dumpsites, and seizures the previous year in 2004. Children affected by labs include those children who were residing at the labs, but who may not have been present at the time of the lab seizure, as well as children who were visiting the site.[9]

EPIC NCLSS numbers indicate a lower percentage of children present compared to Washington State reports of children present at a third of lab seizures. However, the national database does not include reports from all counties in Washington State, and definitions of what it means to be a child "affected" by a lab can differ.

One of the sad facts that arises from the ease of production of methamphetamine is that it is often undertaken in homes, apartments, or trailers occupied by families with children.

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[8] Governor's Council on Substance Abuse. *Governor's Council on Substance Abuse Report on Methamphetamine Abuse in Washington State.* May 2000. Washington State Department of Community, Trade and Economic Development. Olympia, WA.

[9] ONDCP. Drug-Endangered Children.
http://www.whitehousedrugpolicy.gov/enforce/dr_endangered_child.html

Children at lab sites are virtually unprotected from hazards presented by a variety of dangerous chemicals including toxicity from chemical contact, and a very high risk for fire or explosion.

Chemicals used in meth manufacture include explosives, solvents, metals, salts, and corrosives. Processing (cooking) by-products, fumes, vapors, and spillage can also be toxic.[10] Chemicals enter the body by being breathed, eaten, injected (accidental or on purpose), or absorbed by the skin. Health effects from exposure identified by the Washington State Department of Health include shortness of breath, cough, chest pain, dizziness, lack of coordination, headache, nausea, fatigue, chemical irritation, burns, and, in severe cases, death. Chronic exposure to some of the toxic chemicals used in the manufacture of meth have been tied to cancer, brain damage, liver damage, kidney damage, birth defects, and reproductive problems.

Meth labs have other associated dangers, including risk of fire or explosion from careless handling and overheating of highly volatile hazardous chemicals and waste. The Northwest High-Intensity Drug-Trafficking Area Program reports that approximately 15 percent of meth labs are discovered as a result of a fire or explosion.[11]

The nature of the illegal activities means that firearms are frequently present, creating additional hazards. Caregivers, often addicted drug users themselves, are far more focused on the production of their drugs than the welfare of their children.

Child Abuse and Neglect

Thirty-four percent of child welfare cases in Washington State in 2004 were substance abuse related.[12]

Northwest High-Intensity Drug Trafficking Area (HIDTA) reported significant increases in the number of meth-related dependency cases around the state based on information from the Washington State Attorney General's Office. Specifically, Assistant Attorneys General representing the Department of Social and Health Services in the Bellingham, Kennewick, and Vancouver offices estimate that 80 to 100 percent of all new cases involve parents using meth. The Washington State Attorney General also reported that in Benton and Franklin Counties, 160 of the 250 children in foster care (64 percent) have been placed because their parents use methamphetamine.[13]

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[10] Washington State Department of Health Office of Environmental Health and Safety. *Illegal Methamphetamine Labs Fact Sheet.*

[11] Mfiles Meth and Marijuana Resource Tool. *Labs Put Kids at Risk.* http://mfiles.org/ChildrenFoundMethLabs.htm

[12] Children's Bureau. Child and Family Services Review -- Washington State. Washington, DC: U.S. Dept. of Health and Human Services Administration for the Children and Families Administration on Children, Youth and Families, Children's Bureau, 2004.

[13] Northwest HIDTA (March 2006). Northwest HIDTA Threat Assessment. Methamphetamine and Related Crime: The Impacts of Methamphetamine Abuse.

Caregivers who use meth are prone to impulsive actions and are impacted by the psychotic effects that include a heightened state of anxiety and paranoia. In withdrawal, they are very irritable, irrational, and eventually can be comatose for extended periods, even days at a time. When using meth, these caregivers are at high risk to neglect or abuse their children. Children coming out of these homes often have significant health and developmental issues.

Because methamphetamine is known to enhance sexual contact, children are susceptible to sexual abuse and exposure to pornographic materials. Children are frequently victims of hazardous contamination, unsanitary and unsafe living conditions, and abuse that require the intervention and removal by Child Protective Services (CPS).

System Problems and a Search for Solutions

When a lab operation is "busted," one of the problems facing law enforcement officers is how to deal with any child and other caregiver who may be present. If an adult male with a female accomplice is arrested, police are hard-pressed to arrest the female as well when children are present, particularly if there is not a ready alternative for the care of the children, e.g., a nearby relative. Where appropriate, children will be turned over to Child Protective Services; however, there is not always a placement available for the children, particularly in rural areas.

There is, therefore, a crucial need for social service resources to deal with childcare and family issues that arise from the arrest of a caregiver. Besides the need for alternative custody or accountability of the other caregivers, the children must be assessed as to need and appropriate placement. If removed from the parent or other guardian, they must be placed accordingly. Whether or not parents are directly involved in meth production, they are often in need of long-term treatment for their addiction to meth.

In response to the needs of children impacted by meth, the Washington State Governor's Meth Coordinating Committee developed guidelines for handling drug-endangered children, Washington's Endangered Children's Assessment and Response, or "We Care."[14] It provides for collaboration between law enforcement, the state's Child Protective Services, local prosecution, and local medical providers. These entities need to communicate with each other and coordinate their responses to the immediate needs of meth-endangered children.

In its 2005-07 Biennial Recommendations for State Policy Action, the Governor's Council on Substance Abuse gave its support to implementation of the We Care guidelines for Drug-Endangered Children. The Council recommended that the We Care Matrix be used to guide the development of local response protocols. The protocols would address situations where there is reasonable cause to believe that abuse and neglect of a child has occurred due to the parent's or guardian's addiction to controlled

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[14] Washington State Governor's Meth Coordinating Council. *We Care: Recommended Best Practices Addressing the Needs of Drug Endangered Children*. August 2004.

substances, or due to the child's direct exposure to chemicals and processes involved in the manufacture of illegal drugs.

The Governor's Council on Substance Abuse recognizes that each county and community impacted by meth is unique and may have differences in its needs and available resources that will influence the type of response and procedures for drug-endangered children that are implemented.

Through the Washington Meth Initiative, training sessions are being provided across the state to assist local Meth Action Teams with developing action plans for the implementation of local procedures using the We Care Matrix as a guide. These Meth Action Teams, in turn, provide leadership and support to identify and coordinate resources in a manner tailored to best meet the local needs of each county given available resources.

Successful DEC programs already exist in many Washington counties. The We Care Matrix was recommended by the Council in the spirit of inter-agency cooperation with the hope that it would be used in conjunction with established programs and existing resources statewide to develop successful approaches for drug-endangered children that will assure better future outcomes.

The present study surveys the status of local DEC procedures in Washington State. The purpose of this study was to identify local procedures, whether formal or informal, for handling drug-endangered children; and to compare these procedures to the steps recommended by the We Care Matrix.

In the course of developing the survey, other research questions emerged, including whether DEC procedures differ when a child is drug-endangered through parental abuse or neglect versus when a child is endangered through direct exposure to a drug or associated toxic chemicals. Additionally, this study explored whether counties have different procedures when a child is endangered by a drug other than meth, such as other illicit drugs, alcohol, or prescription drugs.

It is important to note that this study asks what procedures are in place, but does not ask why particular procedures are used, how frequently they are needed, or how consistently they are implemented. These are topics for future research. The following report is only an inventory of what is currently in place in areas served by the respondents. It is hoped this inventory will facilitate information-sharing and identification of existing resources.

METHOD

The survey follows the components of the We Care Matrix, assessing the existence of local protocols for drug-endangered children across four DEC-impacted systems:

- Law Enforcement

- Child Protective Services
- Medical Services
- Prosecutor

Four surveys were developed, one tailored to each system. Community Mobilization Coordinators in the 39 counties were asked to identify a county representative for each of these four areas to respond to the survey.

Survey Development

Numerous persons were consulted in the design of the survey. Those who gave generously of their time included persons from DSHS Children's Administration, Washington State Patrol, Washington State Patrol Toxicology Lab, Washington Association of Sheriffs and Police Chiefs, Washington Association of Prosecuting Attorneys, Washington State Attorney General's Office, Mary Bridge Children's Hospital, and Washington State Department of Health.

In the fall of 2005 additional input was solicited at two regional drug-endangered children training sessions held in eastern and western Washington and sponsored by the National Alliance for Drug-Endangered Children. Over 100 combined attendees (including law enforcement, school district personnel, and attorneys) were given a copy of the proposed survey questions and were ask for suggestions.

The major impetus for the development of drug-endangered children protocols is the child who is abused or neglected due to their parents' or guardian's addiction to meth and their exposure to harmful chemicals at meth lab sites. However, early in the development of this study, several key informants asked the research investigators the question: "If a child is abused or neglected due to the parent's drug addiction, shouldn't the same intervention actions be taken, regardless of the drug or drugs the parent is abusing?" This study does not answer that question; but for each question related to procedures for investigation and placement of drug-endangered children, additional queries were added to determine if the response is different if a child is abused or neglected due to parental addiction to drugs other than meth. This led to the development of five drug categories for which protocols were assessed:

- Meth (child abused or neglected)
- Meth (child directly exposed)
- Illicit Drugs
- Alcohol
- Other drugs (e.g., prescription drugs)

Survey Instrument

The survey was prefaced by a cover letter that explained that "The Governor's Council on Substance Abuse is interested in learning more about how the needs of drug-endangered children are being met in our state. We are compiling a county-by-county inventory of the current resources for drug-endangered children in Washington State."

"Drug-endangered children" were defined as:

"1. Children who there is reason to believe have been **abused or neglected** by the adult (a parent or another adult) responsible for their care due to that adult's abuse of alcohol or controlled substances; or

"2. Children who are at risk because they are being **directly exposed** to alcohol, illicit drugs, or illegal drug manufacturing activities."

Respondents were asked to indicate whether their agency has procedures in place for each component identified in the matrix for their field. Respondents were instructed to answer "yes" if they have a formal or informal procedure, regardless of how frequently they might have cause to use the procedure.

The DEC survey questions can be found in Appendix B. The following is a condensed summary of the questions asked of each of the four system respondents:

Law Enforcement

"For [DEC] in your jurisdiction, is there a law enforcement procedure in place for the following"

- Take child into custody and transfer to CPS
- Collect and submit biological samples for evidence
- Document environmental dangers

Child Protective Services (CPS)

"For [DEC] in your service area, is there a CPS procedure in place for the following"

- Transfer custody from law enforcement
- Locate other dependent children
- Decontamination and/or transport to medical facility
- Collect biological samples
- Transport child to receiving home
- Initial child interview and placement assessment

Medical Services

"For [DEC] in your jurisdiction, is there a medical procedure in place for the following"

- Conduct medical exam of child (within 24 hours if illness suspected; otherwise within 7-14 days)
- Collect biological samples for evidence
- Send biological samples to lab
- Conduct Early Periodic Screening, Detection, and Treatment (EPSDT) within one month of placement

Prosecutor

"For the following types of cases … where [DEC] are involved, does the prosecutor's office have formal or informal procedures in place to consider the case's implications for the children and what legal action may best protect their interests?"

- Criminal cases in general
- Child endangerment cases
- Cases with custody implications

The prosecutor survey also asked respondents to answer several general questions not targeted to specific types of drugs:

- "Has your prosecutor's office charged any cases under RCW 9A.42.100 (child endangerment by methamphetamine manufacture)?"
- "Has your prosecutor's office sought an exceptional sentence or based an increase of the standard range sentence on presence/exposure of children in drug cases?"

As a global indicator, all surveys also asked respondents to note whether there are differences in their procedures for meth versus other drugs, and whether there are differences in their procedures when it is a child abuse/neglect issue versus direct exposure to drugs.

Data Collection

Given limited staff resources, it was decided that the most expedient survey distribution method was to send the surveys to the Community Mobilization coordinators who are co-conveners for the Meth Action Teams (MAT) in each county. MAT leaders played a vital role in the distribution and collection of the surveys. They identified key stakeholders in their counties to fill out the surveys. Community Mobilization coordinators also forwarded the surveys to the stakeholders and served as the contact point for survey returns in their county.

In mid-October, the four versions of the DEC survey were emailed to all Community Mobilization coordinators for distribution. The survey asked respondents to return completed surveys to their Community Mobilization coordinators within two weeks of receipt of the survey. Respondents were given contact information for the researchers in case they had any questions about the survey; only three respondents called for question clarifications.

Originally, data collection was scheduled to be concluded by the end of November 2005. However, due to a low response rate, the deadline was extended twice after follow-ups with the Community Mobilization coordinators—first to January 15, 2006 and ultimately to March 10, 2006—for a total of three months of data collection.

RESULTS

Characteristics of county respondents from each of the matrix areas are described, followed by caveats regarding data interpretation, and then presentation of survey results.

The questions addressed by this study include the following:

- Implementation of matrix categories—what local procedures exist for handling drug-endangered children, and to what extent do they follow the We Care Matrix recommendations?
- Meth vs. other drugs—do procedures differ for meth versus other drugs?
- Child abuse/neglect vs. direct exposure—for meth, do procedures differ for child abuse/neglect versus direct exposure to toxic substances?

Respondent Characteristics

Thirty-two of the 39 counties (82 percent) in Washington State responded to the survey with information from at least one of the four matrix areas. For comparison purposes, counties were divided based on population size into small (population less than 45,000), medium (population greater than 45,000 and less than150,000), and large (population greater than 150,000) counties. The categories were adopted from categories used by the Department of Community, Trade and Economic Development's (CTED) Local Government Fiscal Note Program, based on population figures provided by the Washington State Office of Financial Management, Forecasting Division.

Responding counties, classified by population size, were as follows:

- Overall = 32 out of 39 (82%)
- Small counties = 16 out of 18
- Medium counties = 8 out of 11
- Large counties = 8 out of 10

Surveys received for the four matrix areas were as follows:

- Law enforcement = 29 out of 39 (74%)
- CPS = 28 out of 39 (72%)
- Medical = 27 out of 39 (69%)
- Prosecution = 24 out of 39 (62%)

Represented Counties

Population size categories for Washington State are identified in Table 2. The counties for which data were available are indicated with an "X". This includes responses received from survey respondents as well as responses filled in by the research investigators based on returned comments and available protocols. Counties indicating that they did not have any protocols had data recorded as "no" on all responses.

Responses by an agency that spanned multiple counties (e.g., Chelan-Douglas) were recorded twice, once for each county.

Table 2. Surveys Returned by County Size with Population Rankings

Law Enforcement	CPS	Medical	Prosecutor	County	Total Population	Rank	Unincor-porated	Rank	Incor-porated	Rank	Percent Unincor-porated	Rank
				LARGE								
X	X	X	X	King	1,808,300	1	364,498	1	1,443,802	1	20%	2
X	X	X		Pierce	755,900	2	345,940	2	409,960	2	46%	17
X	X	X	X	Snohomish	655,800	3	315,390	3	340,410	3	48%	19
X	X	X	X	Spokane	436,300	4	121,848	7	314,452	4	28%	5
X	X	X	X	Clark	391,500	5	188,955	4	202,545	5	48%	20
X	X	X	X	Kitsap	240,400	6	167,920	5	72,480	10	70%	32
X	X	X	X	Yakima	229,300	7	89,060	8	140,240	6	39%	9
X	X	X	X	Thurston	224,100	8	126,450	6	97,650	9	56%	22
				Whatcom	180,800	9	79,848	9	100,952	8	44%	15
				Benton	158,100	10	36,075	17	122,025	7	23%	4
				MEDIUM								
	X	X		Skagit	110,900	11	47,250	11	63,650	11	43%	13
X	X	X	X	Cowlitz	95,900	12	40,290	15	55,610	12	42%	12
X	X			Grant	79,100	13	37,660	16	41,440	15	48%	18
X	X	X	X	Island	76,000	14	51,450	10	24,550	21	68%	30
X	X	X		Lewis	71,600	15	43,213	12	28,387	19	60%	26
				Grays Harbor	69,800	16	27,505	20	42,295	14	39%	10
X		X	X	Chelan	69,200	17	29,985	19	39,215	17	43%	14
X			X	Clallam	66,800	18	40,305	14	26,495	20	60%	25
				Franklin	60,500	19	12,455	30	48,045	13	21%	3
X	X	X	X	Walla Walla	57,500	20	16,635	24	40,865	16	29%	6
				Mason	51,900	21	43,165	13	8,735	28	83%	36
				SMALL								
X	X	X	X	Whitman	42,400	22	6,360	35	36,040	18	15%	1
X	X	X	X	Stevens	41,200	23	31,621	18	9,579	25	77%	34
X	X	X	X	Okanogan	39,600	24	23,870	21	15,730	23	60%	24
	X	X	X	Kittitas	36,600	25	15,375	25	21,225	22	42%	11
X		X		Douglas	34,700	26	21,780	22	12,920	24	63%	27
X	X	X	X	Jefferson	27,600	27	18,855	23	8,745	27	68%	31
X		X	X	Pacific	21,300	28	14,200	26	7,100	30	67%	29
X	X		X	Asotin	20,900	29	12,490	29	8,410	29	60%	23
X	X	X	X	Klickitat	19,500	30	12,960	28	6,540	31	66%	28
X	X			Adams	17,000	31	8,230	33	8,770	26	48%	21
X	X	X	X	San Juan	15,500	32	13,350	27	2,150	35	86%	38
				Pend Oreille	12,200	33	9,210	31	2,990	33	75%	33
X	X	X	X	Skamania	10,300	34	8,299	32	2,001	36	81%	35
X	X	X	X	Lincoln	10,100	35	4,470	36	5,630	32	44%	16
X	X	X	X	Ferry	7,400	36	6,425	34	975	38	87%	39
				Columbia	4,100	37	1,255	38	2,845	34	31%	7
X	X	X		Wahkiakum	3,900	38	3,350	37	550	39	86%	37
	X			Garfield	2,400	39	885	39	1,515	37	37%	8
				WA State	**6,256,400**		2,438,882		3,817,518		39%	

Population data from Washington State Office of Financial Management, Forecasting Division, 6/28/05

Represented Agencies and Organizations

Community Mobilization coordinators were asked to identify one respondent for each of the matrix areas (law enforcement, Child Protection Services, medical, and prosecution) that best represented their county. In interpreting the results tables, it is important to note that the combination of matrix category, agency, and job position of the respondent determine how much of the county is represented in the survey response. An index of respondent agencies and job positions is presented in Appendix A.

For example, Child Protection Service (CPS) is an agency that serves the entire county. Therefore, a CPS survey response represents CPS procedures for the entire county. Although prosecutors also represent the entire county, in some cases the respondent was a deputy prosecutor in a particular division of the prosecutor's office. Therefore, prosecutorial responses do not necessarily represent an entire county.

Law enforcement officers and medical professionals come from agencies and organizations that represent a limited area of service. For example, most law enforcement respondents were from sheriffs' offices (83 percent). These offices serve the unincorporated areas of the county. The population table (Table 2) lists the unincorporated population of each county. A response from someone from a sheriff's office would represent procedures in existence only for unincorporated areas served by that office. The response would be limited further by the officer's personal knowledge based on the unit in which the officer works.

Medical respondents came from a variety of sources, including private practice, local hospitals, medical centers, and public hospital districts. Without further investigation, it is unknown what geographic area and/or population is served by each of the responding entities. In general, Community Mobilization coordinators endeavored to send the survey to medical facilities that are most likely to see drug-endangered children. However, there can be multiple medical facilities in each county to which these children might go.

Since survey respondents do not necessarily represent the entire county, procedures reported by one respondent do not necessarily cover drug-endangered children countywide. Correspondingly, a lack of procedures reported by one respondent does not necessarily mean a lack of DEC procedures countywide for the respondent's matrix category. The data does, however, provide what is hopefully a representative first look at DEC coverage across the state.

In interpreting the results, it is important to recognize that lack of procedures does not mean a lack of initiative or dedication. As one prosecutor's office commented: "Our absence of procedures/protocols should not be interpreted as a lack of interest or caring. We would welcome information, training, and templates from those who have the tools already in use."

Data Interpretation

Several data issues arose in the course of this survey. First, although most responses were entered as submitted, some missing or inconsistent data was corrected. Second, it became apparent from some responses that respondents could and did interpret some questions in different ways.

Data Corrections

The first part of each survey consisted of a series of checkbox questions. Most responses were recorded as submitted. However, some checkbox responses were modified as follows:

- One county had two law enforcement responses turned in for the same survey; for any question that had a "yes" from one respondent and a conflicting answer from the other ("no", "don't know" or "N/A"), the "yes" response was recorded.
- One county had a CPS respondent who left many checkboxes blank, whose responses were filled in by the researchers based on statements made in the open comment section of the survey.
- One county had medical responses indicating "not applicable" when it was apparent from written DEC procedures that a different medical facility in the county did have protocols in place. In those situations, the "not applicable" response was changed to "yes."
- Written protocols that were received were used to complete missing responses for 11 surveys.
- Five surveys for which counties indicated that there were no DEC procedures were recorded as having all "no" responses. Note that for some questions this led to responses of "no" even though all respondents were expected to have procedures for it (e.g., CPS placement of the child).

Question Interpretation

There appeared to be some confusion in interpretation of what it means to have a "procedure." Some respondents said "yes" to having a procedure when the respondent's agency was responsible for the action. Whereas others indicated "yes" even if their own agency wasn't in charge of the action but was responsible for setting in motion a chain of events that would lead to the action (e.g., law enforcement could either collect biological samples, or direct CPS to collect the biological samples, and both could lead to a "yes" response).

Some comments ("we follow state requirements") suggest that there could be interpretation differences in the definition of DEC "procedures," such as whether or not it includes procedures already mandated by state law.

Responses were generally left as entered unless they directly conflicted with a written comment or procedure that was included by the respondent.

Implementation of Matrix Categories

For each of the four matrix areas (law enforcement, Child Protective Services, medical, and prosecutor), results are presented as follows:

- We Care Matrix guidelines are reproduced in their entirety in text boxes.
- Bar graphs show the percentage of respondents reporting in which their agency or organization has the listed procedure in place for handling drug-endangered children: one graph for all counties, and additional graphs for small, medium and large counties.
- Specific percentage values referred to throughout the Results Section can be found in Appendix B.

Law Enforcement (LE)

Under the We Care Matrix, law enforcement's recommended role is to assess the condition of the child, place the child in protective custody, and collect physical evidence.

Table 3. We Care Matrix—Law Enforcement Response

1 Secure the scene and ensure the safety of initial responders and civilians present.

2 Contact 9-1-1 if a child has obvious injuries or illness.

3 Take child into protective custody and notify CPS to respond at the scene.

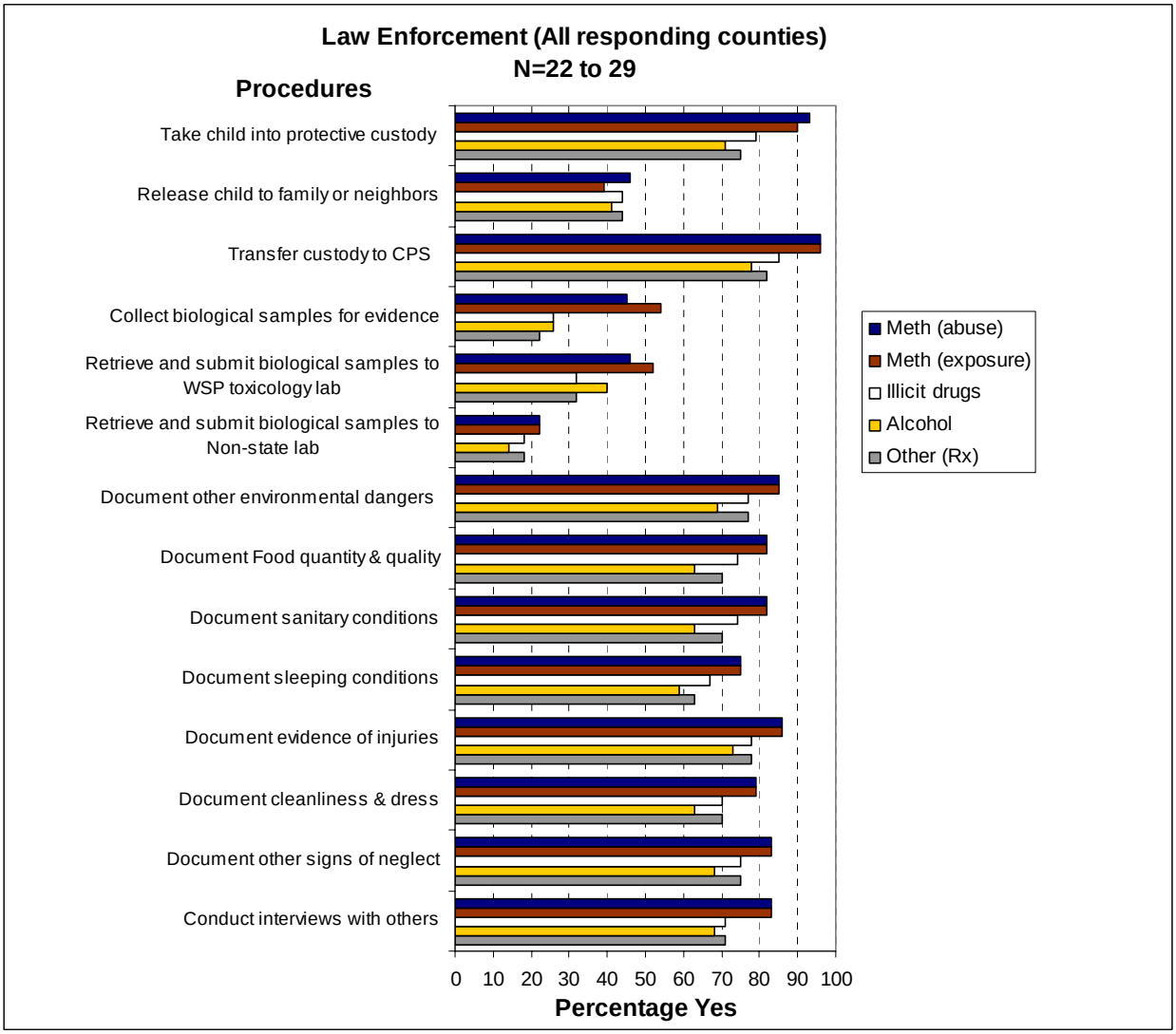
4 Transfer custody of the child to CPS.
   a. LE does not release child to family members or neighbors. CPS oversees placement of child.
   b. CPS attempts to locate and coordinate placement of children that are not on the premises.

5 Acquire warrant for collection of biological samples to be used as evidence for legal prosecution: Retrieve and submit samples to the Washington State Patrol's forensic laboratory.

6 Notify narcotic detectives who start the DEC investigation.
   a. Examine the scene for evidence that indicates the presence of children.
   b. Take measurements comparing the height and reach of the child in relation to the location of the lab items/equipment.
   c. Document and video or photograph the scene giving particular attention to the following risk factors:
      i. Children's accessibility to drugs, chemicals, syringes, and drug paraphernalia
      ii. Proximity of hazards to children's play and sleep areas
      iii. Non-drug hazards and other indications of neglect
      iv. Access to pornography
      v. Access to weapons
      vi. Food quantity and quality
      vii. Sleeping conditions
      viii. Sanitary conditions
   d. Photograph the children at the scene and document the following:
      i. Injuries
      ii. Cleanliness and dress
      iii. Signs of neglect
   e. Interview neighbors, school officials, and other witnesses.

As shown in Figure 3, most law enforcement agencies have DEC procedures for taking a child into protective custody (90 percent to 93 percent of respondents for meth, and 71 percent to 79 percent for other types of drugs). Most law enforcement agencies also have DEC procedures for transferring custody to Child Protective Services (96 percent of respondents for meth; and 78 percent to 85 percent for other types of drugs).

Figure 3. Law Enforcement Procedures for All Responding Counties



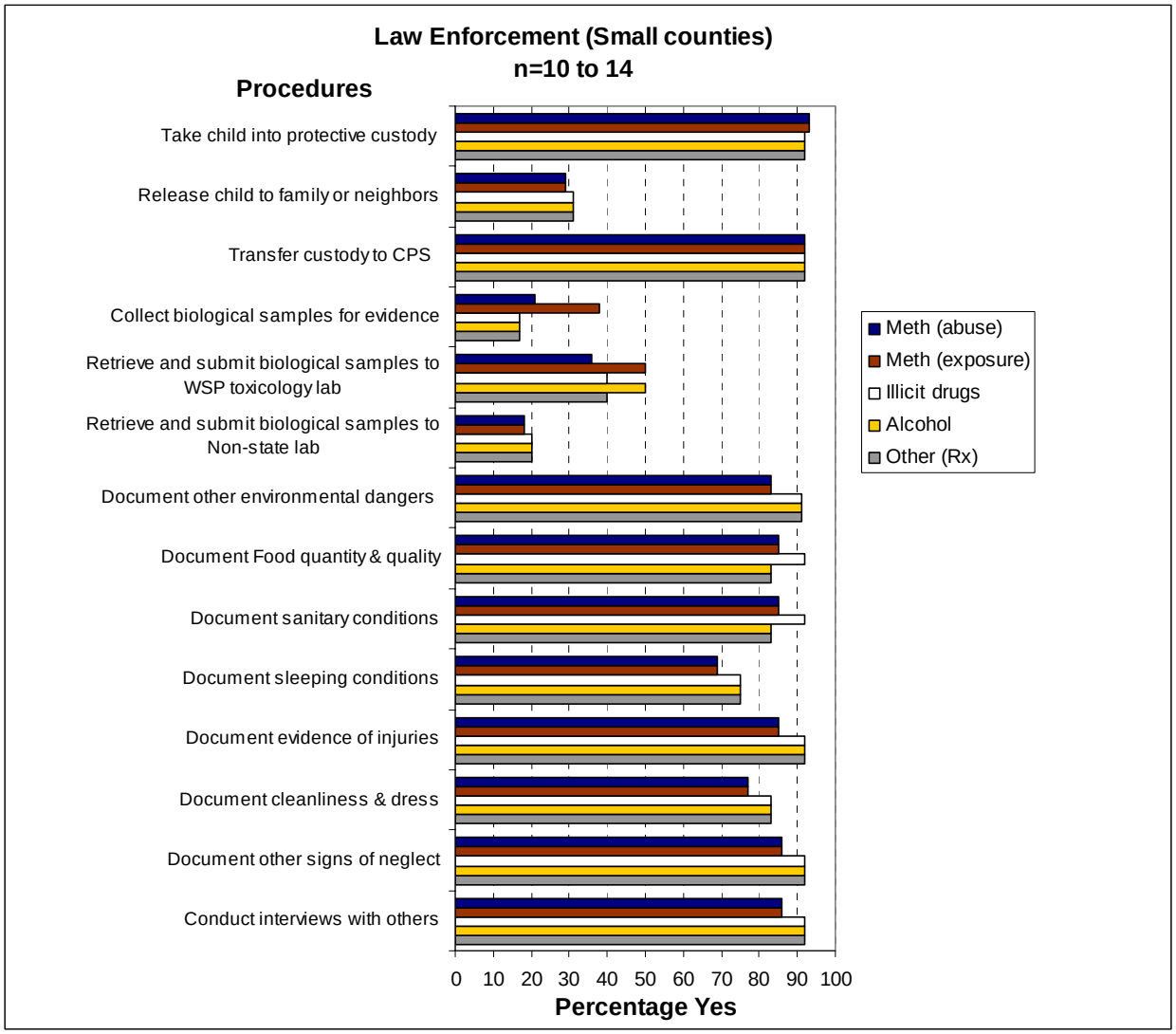
Many law enforcement respondents also reported having extensive documentation procedures for environmental risk and childcare conditions following the We Care Matrix categories. Law enforcement procedures for documenting evidence were reported by 75 percent to 85 percent of respondents for meth, and 59 percent to 78 percent of respondents for other drugs (depending on type of drug and type of evidence documented).

Fewer law enforcement respondents reported procedures for collecting biological samples or submitting the samples to a lab (22 percent to 54 percent). Law

enforcement agencies in larger counties appeared more likely to collect biological samples compared to those from smaller counties, particularly in meth-related cases. As graphically represented in Figures 4 to 6, six of eight respondents from large counties reported having procedures for collecting biological samples for evidence in meth cases, compared to four of seven for medium counties and only four of 14 for small counties (averaging responses for abuse/neglect and direct exposure cases).

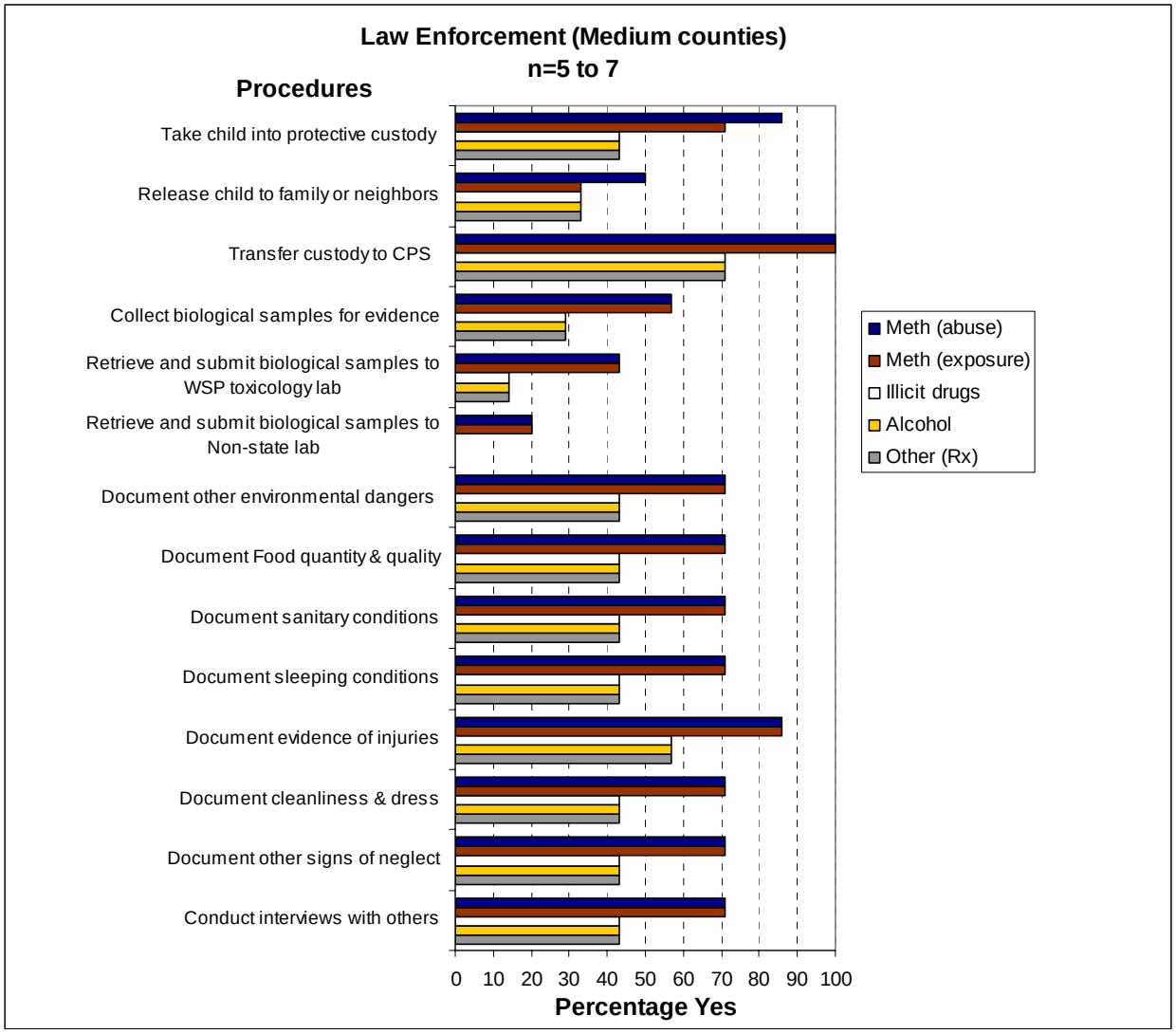
In terms of type of drug, DEC procedures were most common for meth, whether for abuse/neglect or direct exposure meth cases. Law enforcement agencies reported having DEC procedures for meth more often than for other drugs on almost every question. DEC procedures for alcohol were least common.

Figure 4. Law Enforcement Procedures for Small Counties



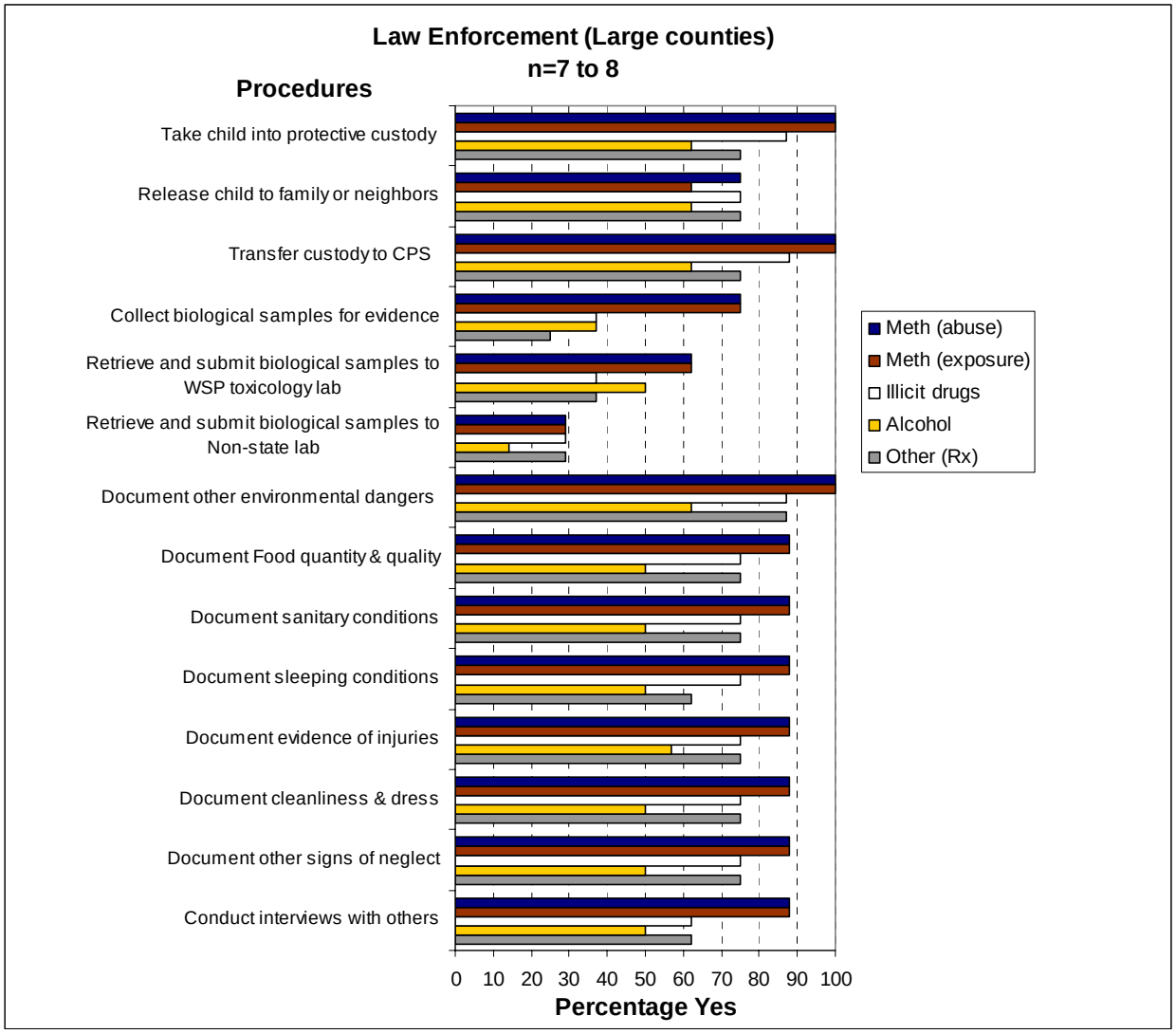
Note: Small sample sizes limit generalizability of results.

Figure 5. Law Enforcement Procedures for Medium Counties



Note: Small sample sizes limit generalizability of results.

Figure 6. Law Enforcement Procedures for Large Counties



Note: Small sample sizes limit generalizability of results.

Child Protective Services (CPS)

Under the We Care Matrix, CPS's role is to accept transfer of custody of the drug-endangered child from law enforcement; coordinate urine sample collection; arrange for decontamination of the child; conduct the initial interview with the child; transport the child to the appropriate facility; conduct a placement assessment; and, after the court makes a placement determination, ensure a continuum of care for the child.

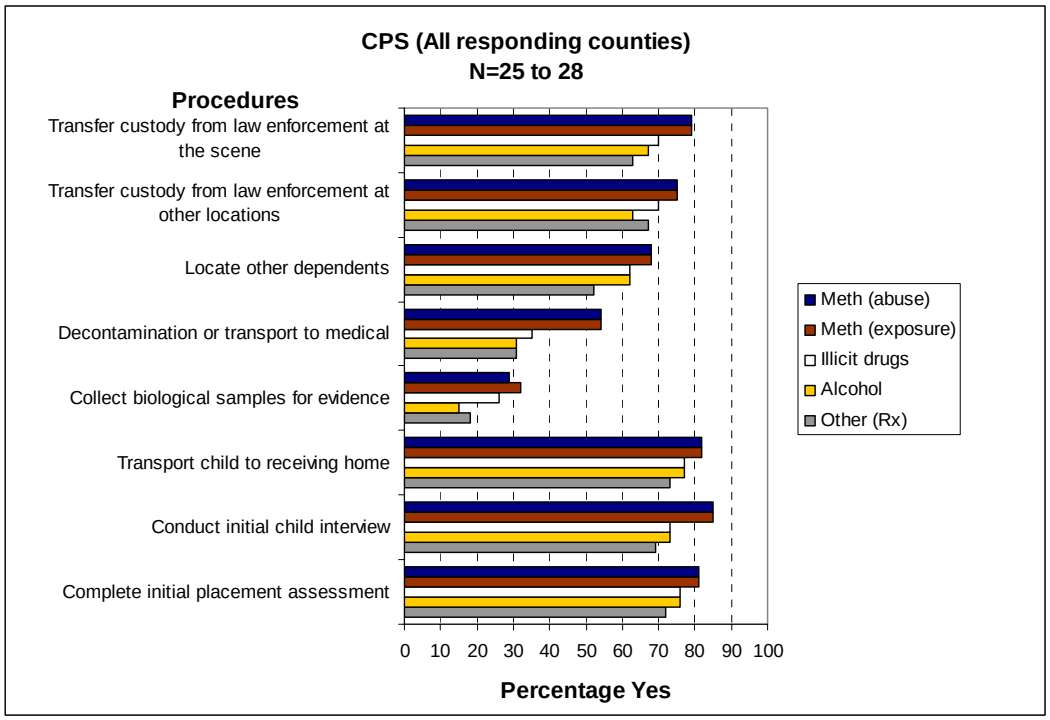
Table 4. We Care Matrix—CPS Response

1. Respond at the scene.
2. Accept transfer of custody of child:
   Attempt to locate and coordinate removal of children that are not on the premises.
3. Call referral into CPS office.
4. Coordinate collection of urine sample, whenever possible within four hours of assuming custody (To accurately document the child's exposure to drugs, a urine sample should be collected as soon as possible after assuming custody. Samples collected beyond twelve hours are unreliable.):
   Sample may be collected at a medical facility or in the field by specially trained professionals.
5. Arrange for decontamination of child:
   At the site, provide clean clothing and wash exposed skin, either using paper towels, soap, and water; or packaged pre-moistened wipes. Child is bathed at the receiving home.
6. Conduct initial interview with child:
   Forward appropriate reports to law enforcement and prosecutor.
7. Transport child to receiving home or medical facility:
   a. Items from the drug lab site are left on site and not taken with the child.
   b. Transport vehicle should have disposable car seat covers and infant and child car seats.
8. Make placement assessment:
   Foster care vs. Relative care.
9. Court makes legal determination within 72 hours of assuming custody.
10. Receiving home arranges a medical exam through child's primary medical provider:
    a. Within 24 hours for child with suspected illness.
    b. Within 7-14 days for child who does not exhibit illness.

As shown in Figure 7 on the following page, over 80 percent of respondents have procedures for initial child interview and placement assessment.

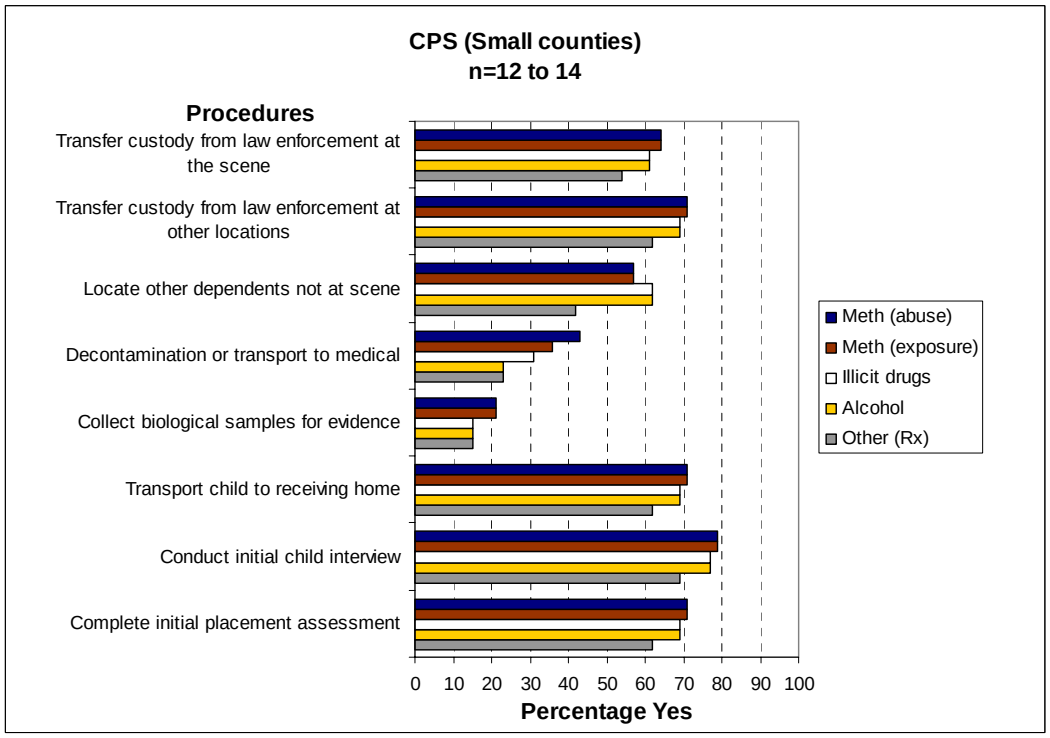
Over 50 percent of respondents reported that CPS is responsible for decontamination and transporting children for meth cases. Medium and small counties were more likely than large counties to have procedures that provide a uniform response for drugs other than meth. Most counties reported fewer procedures for responding to abuse and neglect situations associated with other drugs.

Figure 7. CPS Procedures for All Responding Counties



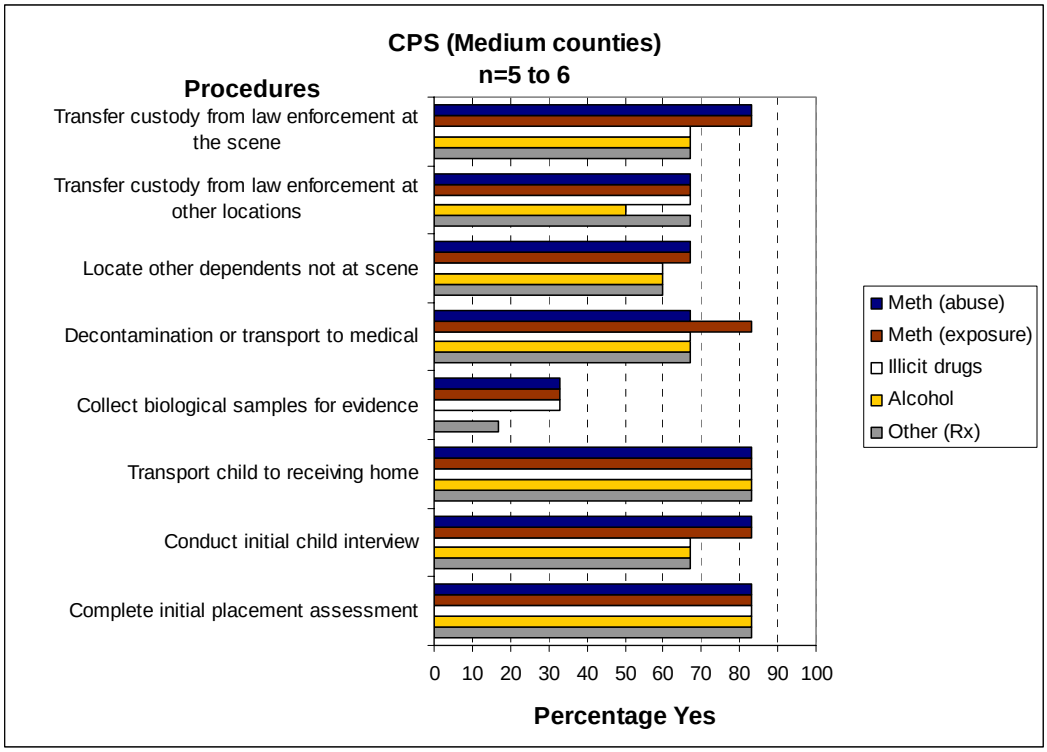
Patterns of responding for small, medium and large counties (shown in Figures 8-10) were similar to the pattern exhibited by all counties combined.

Figure 8. CPS Procedures for Small Counties



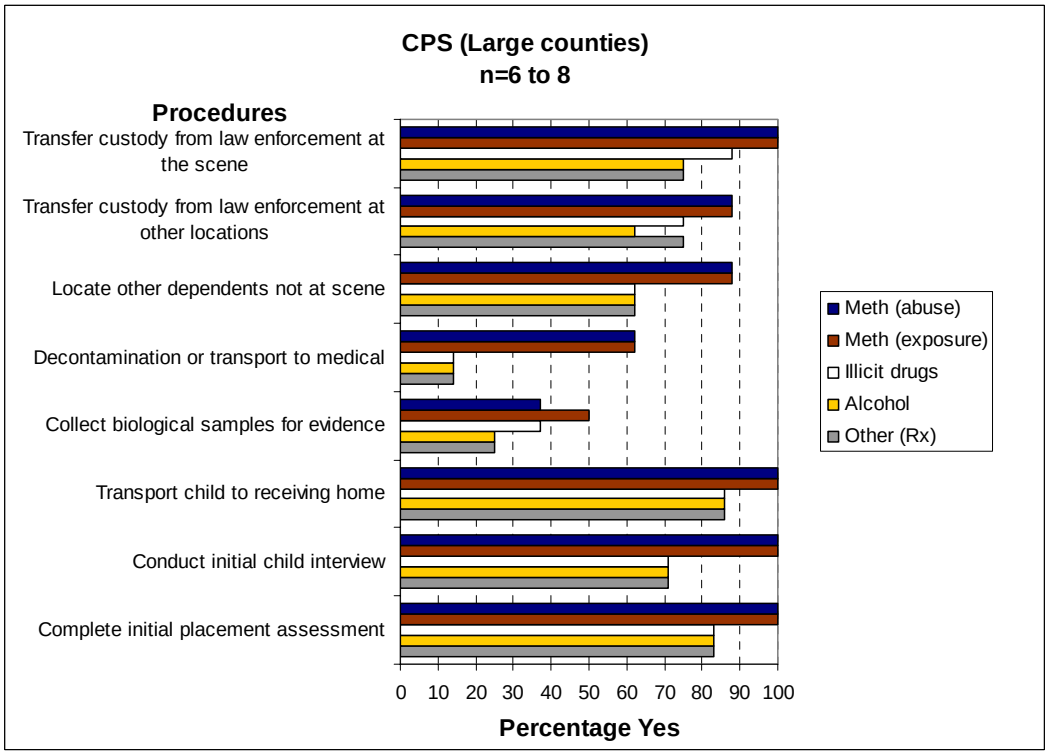
Note: Small sample sizes limit generalizability of results.

Figure 9. CPS Procedures for Medium Counties



Note: Small sample sizes limit generalizability of results.

Figure 10. CPS Procedures for Large Counties



Note: Small sample sizes limit generalizability of results.

One county's CPS worker described their procedures as follows:

> "Generally for those cases in which it is known that children are endangered, i.e., police are doing a raid on a known drug house, if they know there are children involved they will call us to meet them on the scene. If placement or medical care is needed LE will place the children in Protective Custody and do a Transfer of Custody to the Department. Placement and medical care or decontamination is arranged by the social worker. If we discover drug issues in the course of an investigation and a crime may have been committed, we would report this to the police who will participate as needed in further investigation. We can also ask for them to do a Protective Custody Hold on a child, or we can file a Dependency Petition and get a court order for the removal of a child from his home."

Medical Services

Medical responsibilities under the matrix include conducting a timely medical exam; collecting a urine sample within four hours; conducting an Early Periodic Screening, Detection, and Treatment (EPSDT) exam within one month of placement; and conducting follow-up exams as needed. It is worth noting that the necessity and value of urine collection is a matter of debate in the criminal justice and medical community. (See Table 5. "We Care Matrix—Medical Response" on the following page.)

Table 5. We Care Matrix—Medical Response

1 Child is placed in protective custody by responding Law Enforcement (LE) officers.

2 Child with obvious injury, illness, or respiratory distress is immediately transported to medical facility by calling 911.

3 Child with suspected illness receives medical exam within 24 hours of assuming custody. However, a urine sample is collected, whenever possible within four hours of assuming custody. Medical exam is performed by the child's primary medical provider.

4 Child who does not exhibit illness receives medical exam within 7 to 14 days after assuming custody. However, a urine sample is collected, whenever possible within four hours of assuming custody. Medical exam is performed by the child's primary medical provider.

5 Medical exam consists of:

- a. Medical History: CPS assists by obtaining medical records and history from parents
- b. Physical Exam: Attention to nutrition, dental decay, respiratory distress, brief developmental screen
- c. Lab Tests as Needed: Consider Complete Blood Count (CBC)

6 Urine sample:

- a. Collected, whenever possible within four hours of being placed in protective custody, at either a medical facility or in the field by specially trained professionals.
- b. Obtained for either:
  - i Child protection, safety, and health reasons: No warrant required.
  - ii Legal prosecution of caregivers: Warrant required, Washington State Patrol (WSP) forensic laboratory collection protocols, and Police Evidence System adhered to. Analysis conducted at the WSP forensic laboratory.
- c. Analyzed to detect and report the presence of illicit drugs at any level.

7 Early Periodic Screening, Detection and Treatment (EPSDT) exam conducted within one month of placement, as required by DSHS.

8 Follow up medical exams conducted as needed.

URINE COLLECTION PROCEDURES

Persons who collect urine samples should be trained in the proper collection procedures and maintain sensitivity towards the child's situation.

1 For urine collection from an infant, place four 4 X 4 gauze pads in the diaper. Remove when wet and place in clean leak proof urine container. Cover, label, and seal in a biohazard container.

2 For urine collection from a child who is potty trained but too young to use a urine collection cup, use a clean urine collection "hat." Place the hat in the toilet and have the child urinate into the collection hat. Transfer the urine to a clean leak proof urine container. Cover, label, and seal in a biohazard container.

3 For older child and adolescent, give the clean urine collection cup to the child and instruct them to urinate into the cup. Cover, label, and seal in a biohazard container.

HAIR SAMPLES

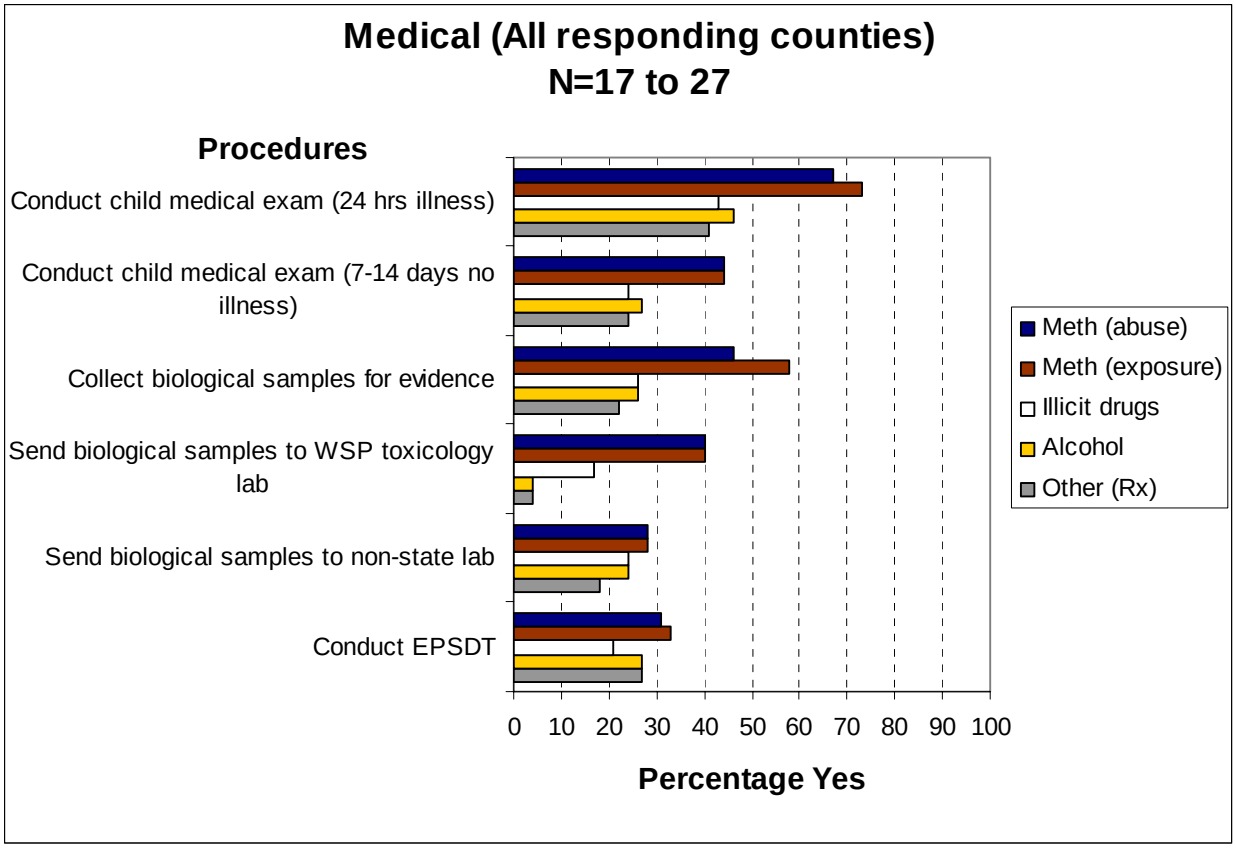
At this time it is recommended not to collect hair samples. Additional research is underway to determine the need for this practice. If DEC teams decide to take hair samples, contact Ann Marie Gordon at mailto:ann.gordon@wsp.wa.gov to arrange for training in collection procedures.

As can be seen in Figure 11, medical provider respondents reported having procedures in place for meth-related DEC cases more often than for cases involving other drugs—for every type of procedure asked about in the DEC survey. Examples of procedures that were more common for meth than for other drugs include:

- Conducting a medical exam within 24 hours if illness is suspected
- Conducting a medical exam within 7 to 14 days if illness is not apparent
- Collecting biological samples.

Out of all medical procedures, conducting a medical exam within 24 hours was the most prevalent procedure.

Figure 11. Medical Procedures for All Responding Counties



Almost three-fourths (73 percent) of medical respondents indicated that they have protocols for conducting a medical exam within 24 hours for direct exposure to meth if illness is suspected. Two-thirds (67 percent) indicated that they have protocols for conducting a medical exam within 24 hours for meth-related child abuse if illness is suspected. However, less than half of the respondents (41 percent to 46 percent) reported a procedure for conducting medical exams within 24 hours for children exposed to drugs other than meth if illness is suspected.

If no illness is apparent in the child, medical providers were less likely to have a procedure for conducting a medical exam within 7 to 14 days. Specifically, only 44 percent reported having such procedures for meth, and only 24 percent to 27 percent reported having such procedures for other drugs.

Medical providers without DEC procedures commented that cases are treated on a case-by-case basis.

> "I do not agree with obtaining medical tests universally. I agree tests should be obtained for diagnostic purposes as clinically indicated. Do not buy into the hysteria of testing all kids for meth. Focus on the science. Do we test all kids for alcohol in alcoholic families? No, not unless clinically indicated."

> "Acute situations requiring immediate evaluation and treatment are handled at the Emergency Department. Non-urgent and follow-up care is provided by pediatric medical staff at designated clinics."

> "No specific pediatric protocols currently in place—individual cases handled on case-by-case basis by patient's MD."

> "Our policy would be to report to CPS whenever abuse/neglect is suspected."

> "Currently hospital staff consult with pediatricians and do the best they can given their combined knowledge to meet the needs of drug-endangered children."

> "We don't have any policies/procedures set up specifically for children relating to the meth use and its exposure. We would treat them like all other potential "poisonings"—we could contact Poison Control for guidance on known exposed substances."

There were 46 percent to 58 percent of responding medical providers who reported collecting biological samples for evidence for meth, but only 22 percent to 26 percent reported collecting biological samples for other drugs.

About half of the medical provider respondents send biological samples to the state lab for meth cases.

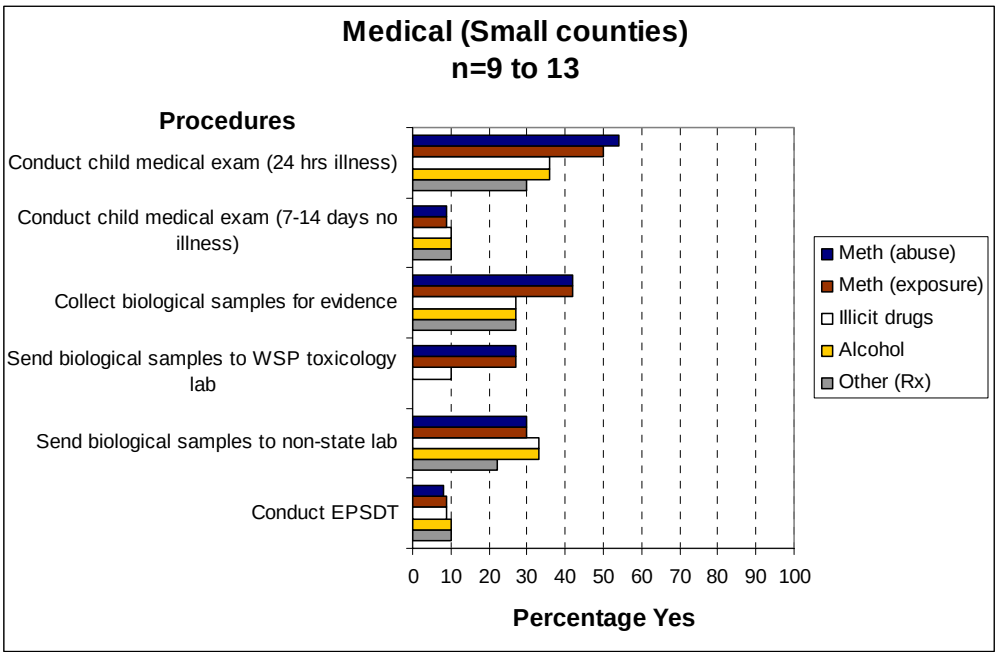
> "Biological samples from meth cases are forwarded to the WSP Toxicology Lab. All other drugs can be handled at [the hospital]. In cases involving evidentiary biological specimens used in legal proceedings, those samples are forwarded to the state lab for processing."

The Washington State Patrol (WSP) toxicology lab tests for lower concentrations of drugs than is typical for hospital labs, which can be important from an evidentiary standpoint. A CPS worker explained the rationale for having the state lab test biological samples:

> "At this time I am conducting the gathering of the UA [urinalysis] sample for children and mailing to WSP lab. Do not have hospital complete UA as it tests at NIDA [National Institute of Drug Abuse] levels."

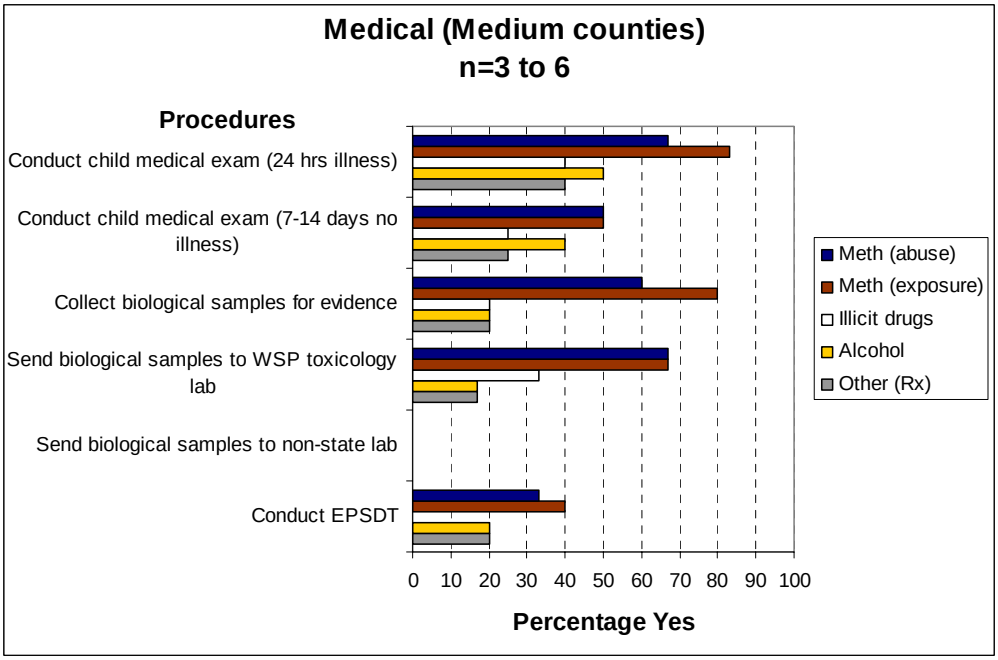
Figures 12 to 14 show medical responses by county size. On the whole, small counties reported having DEC-specific procedures less often than did medium and larger counties. Small counties reported having DEC procedures less often than did medium and larger counties for all We Care Matrix procedures except in regards to collecting biological samples and use of non-state labs.

Figure 12. Medical Procedures for Small Counties



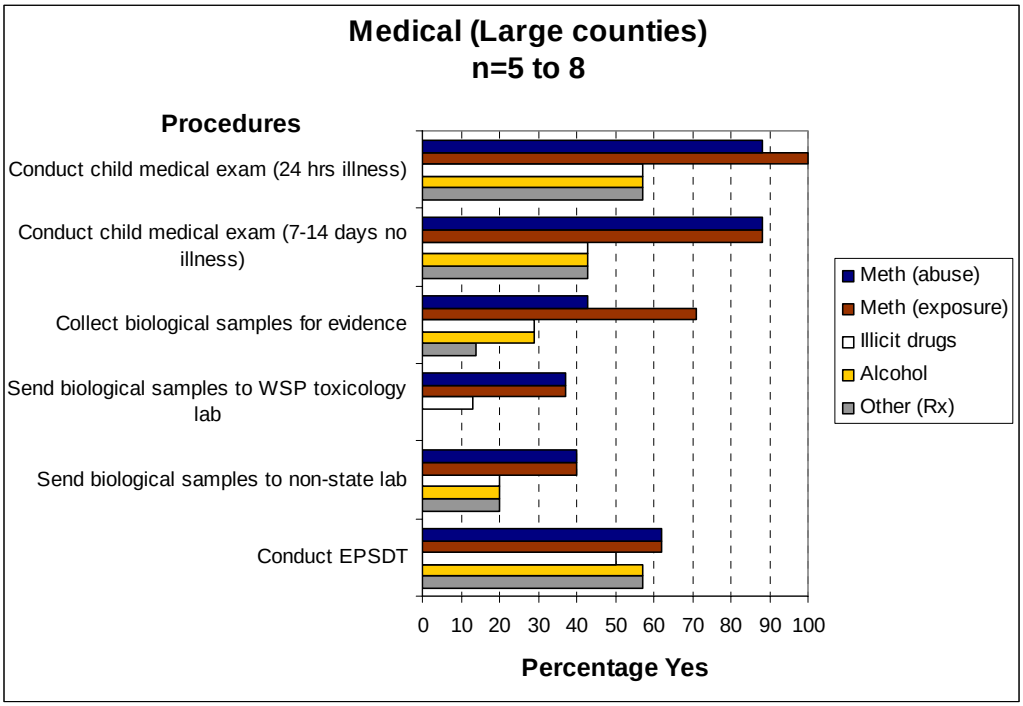
Note: Small sample sizes limit generalizability of results.

Figure 13. Medical Procedures for Medium Counties



Note: Small sample sizes limit generalizability of results.

Figure 14. Medical Procedures for Large Counties



Note: Small sample sizes limit generalizability of results.

Prosecutor

Under the We Care Matrix, the prosecutor should review the evidence and determine a course of action that takes into account the child's interests.

Table 6. We Care Matrix—Prosecutor Response

1 Review evidence collected by:
   a. Law Enforcement
   b. Medical Services
   c. Child Protective Services
   d. Local Health Officer

2 Reference appropriate laws.

3 Determine appropriate actions to take that are in the best interest of the child.

The DEC survey asked prosecutors about their case handling practices in regards to considering the interests of the child, reviewing evidence, bringing child endangerment charges, and seeking exceptional sentences.

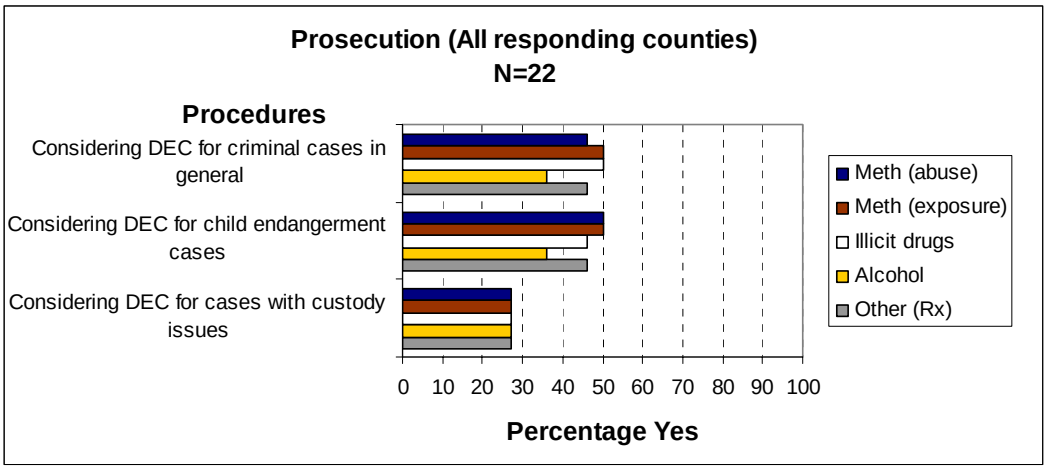
Case Implications for Children

The DEC survey asked about prosecutorial practices that consider the interests of the child in regards to three types of cases: criminal cases in general, child endangerment

cases, and cases with custody issues. The matrix does not address civil legal issues, but custody was included in the DEC survey since child welfare issues can arise in the course of a criminal investigation.

As illustrated in Figure 15, most prosecutor's offices reported that they do not have a procedure to consider a case's implications for drug-endangered children and to consider what legal action may best protect the children's interests; only 27 percent to 50 percent of respondents reported having such a procedure for any of the types of drugs or types of cases asked about in the survey.

Figure 15. Prosecutor Procedures for All Responding Counties



Out of those who did have procedures that consider child implications, larger counties (43 percent to 71 percent of respondents) were more likely to have such procedures than small- or medium-sized counties (20 percent to 40 percent). Responses for small, medium, and large counties are depicted in Figures 16 to 18.

Figure 16. Prosecutor Procedures for Small Counties

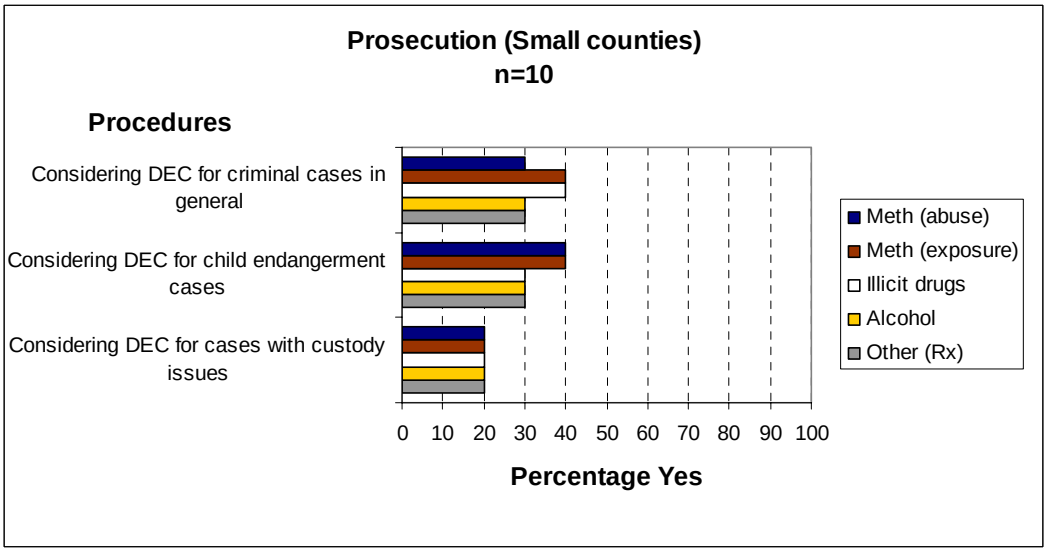


Figure 17. Prosecutor Procedures for Medium Counties

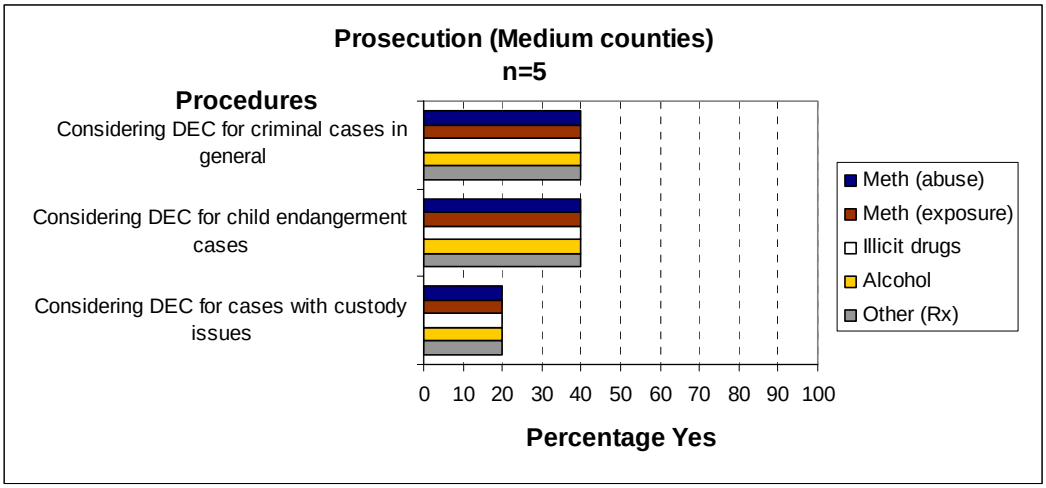
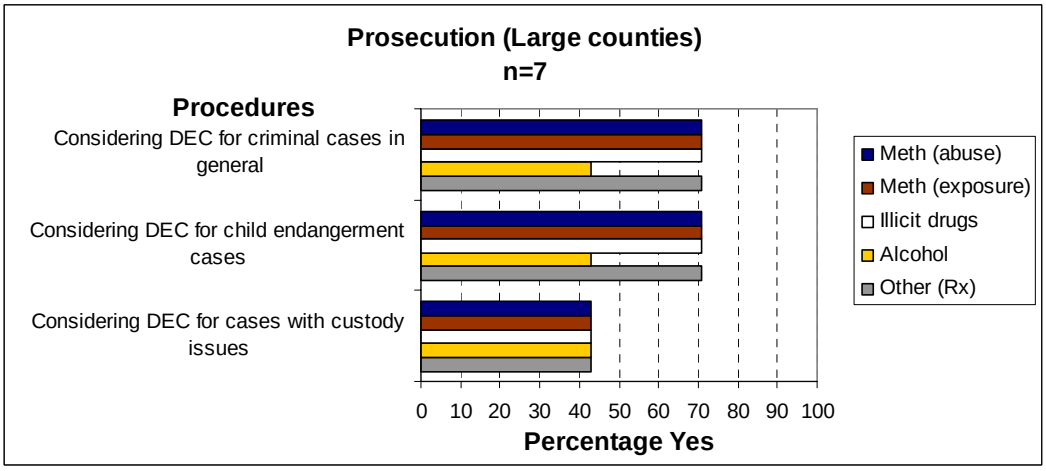


Figure 18. Prosecutor Procedures for Large Counties



Absence of a procedure, however, does not mean that child interests are not considered. Like medical provider respondents, some prosecutors reported that DEC cases are "handled on a case-by-case basis." Just as medical providers are governed by medical standards, lawyers are governed by legal standards.

> "We consider all evidence in each case."
>
> "We have no written policies, but strive to work closely with CPS for child's welfare."
>
> "What we do is a common-sense approach. Despite the lack of written policies, we certainly take into account the presence of the children in all cases, including drug and alcohol cases."

One county prosecutor responded that he did not have the luxury of time to spend working on formal protocols—"I handle these cases on an ad hoc basis. My reality is

that very few reports hit my desk wherein 'child' issues and drugs are implicated. I'm not sure how many cases go unreported."

It was less common to have a procedure that considers child implications for cases involving alcohol (27 percent to 36 percent of respondents) than for other types of drugs (27 percent to 50 percent). Several prosecutor respondents commented that they were unaware of specific procedures related to children who are endangered due to the parent's alcohol abuse.

It was also less common to have a procedure for custody-related cases (27 percent of respondents) than for general criminal cases (36 percent to 50 percent) or child endangerment cases (36 percent to 50 percent). Some of this difference may be because it is less common for a prosecutor's office to handle dependency cases. However, there was an insufficient sample size to explore that possibility. In most counties, the Attorney General's office handles dependency while the prosecutor handles drug cases. In smaller counties, the prosecutor's office is more likely to handle both types of cases. Such was the case for seven responding prosecutor's offices.

One smaller county reported:

> "Ours is a small county. The prosecutor's office handles all aspects of criminal prosecution as well as Dependent Child actions for DSHS/CPS. Due to this overlap, we must consider the possibility of a child welfare case in every criminal case where children are involved. Also, with a very large segment of single parent families, we must consider the ramifications of incarceration of parent on child welfare issues as well."

A prosecutor's office in a large county remarked:

> "When any type of drug case that involves children is referred into our office, the fact that children are involved is flagged in the file. … There is no procedure or policy in place for alerting CPS or other agencies to these cases. … I am also unaware of a procedure or policy in the criminal division that addresses custody issues separately, although the family support unit of our office may address these cases."

Reviewing Evidence

Prosecutors were asked to describe their procedures for reviewing evidence from law enforcement, CPS, and the results of biological sample testing in making determinations of what legal action to take.

Although small sample sizes make broad generalizations difficult, comments received from survey respondents suggest that greater resources available to larger counties result in better evidence collection. Prosecutor's offices from small counties reported missing evidentiary testing opportunities due to response times from other agencies. Medium-sized counties were able to aggressively follow up with obtaining missing

information from investigatory agencies. Some large counties pro-actively trained other agencies in the requirements for handling DEC-related evidence.

Several prosecutors responded that they do not consistently receive the results of biological sample testing. One prosecutor from a small county noted, "In meth manufacture cases we request testing; however, the timing of the reports and response to such requests may result in missing the window of opportunity for testing."

One medium-sized county described its active approach to the gathering of evidence:

> "Reports are submitted by investigating agencies; the reports are date stamped and included in the criminal case report. If police investigation is lacking, we would request follow-up investigatory work that may include additional interviews, forensic measurements and collection of evidence, or laboratory work. Such requests are always in writing, and usually with a deadline. Ordinarily, if we get anything from CPS, it comes at our request, though sometimes their reports are included in police investigation reports."

Prosecutor's offices from large counties were able to offer training to other agencies in the collection of evidence. For example, one office developed literature and a training video for law enforcement. Another office from a large county noted that medical personnel are instructed in the preservation of evidence.

Several counties reported a team approach to working with local child welfare agencies and law enforcement for cases involving children who may have been endangered due to direct exposure or their parent's abuse of meth. One county responded that it was the DEC grant funds it received that allowed it to work closely with law enforcement and social service agencies to screen relevant cases before charges were filed.

Child Endangerment

A person is guilty of the crime of endangerment with a controlled substance if the person "knowingly or intentionally permits a dependent child or dependent adult to be exposed to, ingest, inhale, or have contact with methamphetamine or ephedrine, pseudoephedrine, or anhydrous ammonia, including their salts, isomers, and salts of isomers, that are being used in the manufacture of methamphetamine, including its salts, isomers, and salts of isomers." RCW 9A.42.100. Endangerment with a controlled substance is a Class B felony.

Less than a third of responding counties (29 percent) had charged any cases under the child endangerment laws for meth manufacture. The following number of respondents reported that they had brought child endangerment charges:

- All counties 6 of 21 (29%)
- Small 0 of 10
- Medium 2 of 4
- Large 4 of 7

One respondent said they charge “any time there is a [child] present/exposed to a meth lab and we can prove it!”

Based on respondents’ written comments, a major issue in the decision to charge under child endangerment statutes is whether there is sufficient evidence to charge. One prosecutor lost a meth manufacture case when investigating agencies were unaware of the need for special care in reporting evidence and in biological testing.

Exceptional Sentences

Slightly fewer than half of the prosecutor’s offices in responding counties (43 percent) had sought increased or exceptional sentences based on the presence or exposure of children in drug cases. The number of respondents who had sought sentence increases for DEC cases were as follows:

- All counties 9 of 21 (43%)
- Small 4 of 10
- Medium 1 of 4
- Large 4 of 7

The number of times that offices had sought sentence increases ranged from being routine to rare.

Three respondents commented that they have used the school zone enhancement. Others reported using exceptional sentencing enhancements for cases where children were found at active meth labs or locations where drug dealing was occurring.

Meth versus Other Drugs

Did agencies perceive a greater problem with meth-related DEC as opposed to children endangered by other drugs? In many counties the answer was “yes.” A CPS worker characterized the difference between meth and other drugs as follows:

> “Alcohol use can create as great a risk to children as most other drugs. Meth on the other hand is in a special category. It is highly addictive and seems to create parents that cannot put the needs of their children above the need for the drug.
>
> “Services seem to be less effective in getting children returned because these parents rarely complete the services. Treatment is delayed by these parents for long periods of time. Treatment when it does occur is often effective only while the treatment is intense and the user is out of their usual community and circle of friends. Relapse after treatment is common and happens early after treatment.
>
> Our courts need to begin treating meth crimes and dependency issues related to meth in a way that takes these things into consideration. Parents who deliberately expose not only themselves but their born and unborn children directly to lethally toxic substances on a regular basis are in a different category than those whose addiction leads to neglect of their children or using poor judgment in their behavior around their children.”

Respondents were asked: “Are there differences between your procedures for meth and your procedures when drugs other than meth are involved?” Note that this differs from the bar graph results presented above, which assessed whether agencies have any DEC procedures, but not whether the content of the procedures is the same across different types of drugs. Table 7 reports the percentage of respondents who reported having different procedures for meth versus other drugs.

Table 7. Respondents Reporting That Procedures Differ for Meth versus Other Drugs.

Agency	All Counties	Small Counties	Medium Counties	Large Counties
Law Enforcement	12 of 24 (50%)	3 of 11	3 of 5	6 of 8
CPS	8 of 22 (36%)	4 of 11	3 of 5	1 of 6
Medical	11 of 22 (45%)	3 of 11	2 of 5	5 of 6
Prosecutor	7 of 21 (33%)	4 of 10	2 of 4	1 of 7

Note that once results are broken down by county size, the small sample sizes (e.g., only four prosecutor’s offices from medium-sized counties) make cross-county-size comparisons unreliable.

Law Enforcement

Half of law enforcement agencies report that there are differences in their meth procedures versus their procedures for other drugs (see Table 7 above). Large counties (6 of 8) had the greatest proportion of offices reporting different procedures for meth versus other drugs; small counties had the lowest proportion (3 of 11).

Examples of comments from law enforcement agencies that distinguish between meth versus other drugs include the following:

> “To my knowledge, the only specific ‘protocol’ that exists which includes this level of partnership and detail is for children affected by meth.”
>
> “When meth is involved, we have a procedure set up with CPS to take care of the children. All other drugs are handled on a case by case [basis]. The toxic nature of meth creates an entirely different atmosphere on how we deal with a scene, especially if there are signs that a lab has been or is present in a residence.”
>
> “The DEC statutes help us by defining that this is a clear-cut crime by having children exposed to meth labs/meth chemicals. We have [Special Assault Unit] detectives respond to take the children into protective custody, document the crime scene, and collect evidence. With other drugs, criminal statutes are not present to clearly identify that crime is taking place, i.e., crack babies exposed before birth.”

CPS

A third of CPS agencies (36 percent) reported differences in their meth procedures versus their procedures for other drugs (see Table 7 above). Large counties were the least likely to report differences in procedures (1 of 6 respondents), which was the opposite of law enforcement (6 of 8 respondents).

A CPS worker described the difference created by meth:

> "Meth can contaminate in a passive way and leaves the system in a relatively short amount of time. This creates a more urgent need for medical attention and testing to determine the course of treatment necessary for the child."

In general CPS respondents saw exposure to meth or the chemicals used for the manufacture of meth as more serious than exposure to other drugs. Most respondents indicated that they would take the child for an immediate medical screen if direct exposure to meth or meth chemicals were suspected.

Medical

Responses by medical providers resembled those of law enforcement. Slightly under half of medical provider respondents (45 percent) reported having different procedures for meth versus other drugs. Proportionately more respondents from large counties (5 of 6) reported having different procedures compared to medium (2 of 5) and small counties (3 of 11).

One medical provider described having a specific protocol only for meth:

> "We have a written protocol for dealing with children that may have exposure to meth, including standing orders. For other cases of neglect or abuse we rely on the ER MD to order appropriate labs and staff to document and assess sustained injuries."

Prosecutor

Even though only a third of prosecutor respondents (33 percent) reported differences in procedures for meth versus other drugs, many prosecutor comments described meth-related offenses as more serious than other drugs and more aggressively prosecuted. One respondent indicated that there is more movement in plea-bargaining for other drugs, especially marijuana.

> "While the procedures are relatively similar, meth cases usually involve more intensity in investigation and collaboration with law enforcement and other agencies, particularly when meth production is involved in the case."

> "We typically do not seek testing when other substances are involved."

Meth (Abused) versus Meth (Exposed)

When counties have DEC procedures for children's direct exposure to meth, they also tend to have procedures for child abuse arising from meth use. However, child abuse and direct exposure raise different concerns that may be addressed by different procedures.

Based on a review of protocols and open-ended comments from survey respondents, it appears that if it is a criminal case, law enforcement is more likely to be the driver for the investigation. For cases that are primarily child welfare cases, the driver tends to be Child Protective Services.

When asked "Are there differences between your procedures for when the issue is abuse/neglect due to the caregiver's drug use as opposed to the children's direct exposure to drugs?" The percentage of respondents who answered "Yes" were as follows (see Table 8):

Table 8. Respondents Reporting That Procedures Differ for Meth (Abused) Versus Meth (Exposed).

Agency	All Counties	Small Counties	Medium Counties	Large Counties
Law Enforcement	13 of 24 (54%)	3 of 11	2 of 5	8 of 8
CPS	10 of 20 (50%)	3 of 10	4 of 4	3 of 6
Medical	7 of 20 (35%)	3 of 11	1 of 4	3 of 5
Prosecutor	10 of 20 (50%)	3 of 10	2 of 3	5 of 7

Again, caution is advised when drawing conclusions based on county size, given the small sample sizes (e.g., three prosecutor's offices responding from medium-sized counties).

<u>Law Enforcement</u>

Slightly over half of law enforcement respondents (54 percent) indicated that they have different procedures for meth cases where the child is abused or neglected versus meth cases where the child is directly exposed to toxic chemicals. All of the larger county respondents reported having different meth procedures.

Examples of law enforcement responses where the presence of a lab leads to a different response include the following:

> "There are mandatory procedures required when a meth lab is involved. If it is just meth or other drugs it is left to the officer and situation."

> "Recreational drug users who have children are often not the suspects of crimes unless we can prove that the child is in clear and significant danger (rather than just exposed)."
>
> "For law enforcement the situation is a lot more serious if the child has been directly exposed to drugs, especially with meth."

CPS

Half of CPS respondents reported having different procedures for meth cases involving abuse/neglect versus meth cases involving direct exposure. All of the medium counties reported having different meth procedures.

> "The agency has more of an ability to intervene if the issues are related to abuse and neglect rather than exposure to drugs. Often exposure to drugs is part of a neglectful situation and the possibility that a child might ingest drugs or touch contaminated materials due to lax supervision is part of the risk."
>
> "Children neglected due to the use of certain drugs are more likely to be able to remain in their own home with services being provided than those who were exposed to meth in their own home."

Small counties (3 of 10) were among the least likely to report different meth procedures for abuse/neglect versus direct exposure.

Medical Services

Medical providers were unlikely to report having different meth procedures; only about a third of medical provider respondents (35 percent) reported having different meth procedures for abuse/neglect cases versus direct exposure cases.

A lack of procedural differences is consistent with some comments indicating that children are treated as clinically indicated on a case-by-case basis.

> "No, all DEC children will be screened and treated for exposure/abuse/neglect."

Respondents from a majority of large counties, three out of five, reported that they have different procedures for abuse/neglect versus direct exposure. One large county described the difference in treatment as "Toxin exposure evaluation versus assessment for abuse, neglect, developmental/mental health issues."

Prosecutor

Half of the prosecutor's offices responding to the survey reported that they have different procedures for meth cases involving abuse/neglect versus direct exposure to toxic chemicals. A greater proportion of respondents from medium (2 of 3) and large counties (5 of 7) reported having different procedures compared to small counties (3 of 10).

County resources and ability to dedicate separate units to handling different types of cases could play a role in which counties have separate procedures. For example, with law enforcement, prosecutor's offices, and medical facilities, larger organizations may have the resources to have different units handle different types of cases. This speculation is supported by some of the open-ended comments received by respondents.

Prosecutorial response appears to be driven by law enforcement investigation into potential criminal charges or the potential to make a case under statutes for child abuse and neglect.

> "Deputy prosecutors assigned to the Child Abuse Intervention Center would have primary responsibility for prosecution of cases involving abuse/neglect. Drug Unit deputy prosecutors would have responsibility for prosecution of cases involving exposure."

CONCLUSION

A majority of counties have at least some kind of protocol in place for handling drug-endangered children. Many protocols are meth-specific, whether the issue is abuse/neglect from a drug user or direct exposure to chemicals. Protocols for children endangered by other types of drugs exist but tend to be less common.

Some overall conclusions that can be drawn from the survey results include the following observations:

- More DEC protocols exist for meth than for other drugs.
- Law enforcement tends to take the lead for criminal cases; CPS takes the lead for child welfare investigations.
- Types of protocols vary widely:
  - Whether or not they follow the Matrix.
  - The number and range of collaborating agencies involved.
- Medical facilities tend to have general policies that include meth rather than having meth-specific protocols.
- Greater resources lead to a greater ability to address the specific needs of drug-endangered children.

A Collaborative Response

Some counties follow the We Care Matrix closely, forming DEC protocols from the four matrix areas (law enforcement, Child Protective Services, medical facility, and the prosecutor's office). Other counties may have just one area with its own set of developed protocols that specify how it will interact with the other main players. Some counties take a broader approach than the matrix, soliciting collaboration from a broader range of players including the school district, health department, mental health

treatment providers, and community service agencies. For a good example of a program that takes a strong multi-agency approach, see the Spokane County Collaborative Community Response to Drug-Endangered Children Guidelines reproduced in the Technical Appendix to this report.

One feature that is commonly accepted as good practice is to have strong interagency collaboration in the process. A medical provider respondent stated it well:

> "A multi-disciplinary team is critical to the success of identifying, protecting and intervening with the drug-endangered child. First responders, law enforcement, CPS, prosecuting attorney, foster families, public health nurses, primary care providers, hospital-based physician and nurses are just some of the important components of the team. Frequent, open communication between the agencies to determine the child is receiving the most appropriate care for their safety should also be a first priority."

A general consensus is that the closer law enforcement and CPS work together, the better the response to children's needs. Appropriate medical care that addresses DEC issues is also important. One law enforcement agency that had one of the state's first DEC protocols remarked:

> "We have learned that a direct partnership between law enforcement and CPS is critical to an effective DEC program. Also the cooperation of a local hospital that will follow the medical protocols necessary for these children is very helpful."

Likewise, agency cooperation and communication is important when a drug-endangered child is taken to a medical facility. The facility needs to be adequately apprised of the child's situation, which at a minimum should include informing the facility that the child may have been exposed to hazardous chemicals and require decontamination. One hospital that used to receive drug-endangered children via a CPS liaison working with the narcotics task force stopped receiving those children when CPS cancelled the position (the children now primarily are seen at another hospital). That hospital may still receive children from meth environments, but without the narcotics task force link, the hospital's task is more difficult: "I am sure there are children that come from meth environments, but unless a parent divulges that information we don't have the 'heads up' we had when they were brought through the narcotics task force."

Future Research

This study is a first look at how meth-related child impacts are addressed versus other drugs in each county. It provides an overall picture of DEC protocols that have been implemented statewide.

From here, future studies can expand on the information gathered. Some potential avenues of further exploration include the following suggestions:

- Explore matrix expansions

    - Attorney General, courts, schools, community service organizations, foster care
- Investigate the effectiveness of different models
- Collect more data
    - Missing counties
    - Multiple respondents per system within a county (sheriff and police, etc.)
    - Tribes
- Conduct survey follow-ups
    - In-depth interviews and site visits to model counties (following the matrix) as well as those illustrating common problems (e.g., difficulty in establishing interagency collaboration)
- Explore what happens to drug-endangered children after placement
    - Future child placements and social outcomes (domestic violence)
    - Outcomes from court-based sentencing alternatives
    - Evaluation of model programs (outcomes from family-focused services, wraparound services)

Attached in the Technical Appendix are existing DEC guidelines provided by counties that responded to this survey. These materials contain data that could be used for developing a set of model procedures that incorporates the best features of existing guidelines. Any model procedures would still require tailoring to each county's own unique problems and agencies, and would have to be flexible enough to accommodate the counties' varying funding resources. One county noted a further concern that protocols "have the appearance of increasing liability for local governments. At a previous Meth Action Committee, it was the consensus of the group—and in particular the Sheriff and Prosecutor—to go very, very slow."

At a minimum, it is hoped that this collection of county responses and DEC guidelines will inform counties about what is going on with DEC procedures across the state. Those counties with existing procedures may wish to use this information as a basis for discussing possible modifications to their procedures. Counties without procedures may wish to use this information as a resource for developing their own set of guidelines.

We were greatly encouraged throughout the course of this study by the great motivation, energy, and willingness to help exhibited by county respondents. For example, the King County Sheriff's Office (KCSO) remarked, "The KCSO is happy to share our Policy and [Standard Operating Procedures] with any [law enforcement] Agencies. They can feel free to review it and take what works for them in their local jurisdiction." Likewise, all of the respondents who had DEC materials to share generously gave permission to include them in the Technical Appendix.

Interagency collaboration and inter-county cooperation are vital to addressing drug-endangered children in our state.

APPENDIX A: Respondent Agencies/Organizations

Respondents are not included in the lists below if the job title or organization was left blank, or if the researchers filled in a county's responses based on written policies or procedures (or the absence thereof).

Law enforcement

JOB TITLE	EMPLOYING AGENCY/ORGANIZATION
Patrol Supervisor	City Police Department
Chief Criminal Deputy (2)	County Sheriff's Office
Coordinator, Meth Action Team	County Sheriff's Office
DEC Detective - Investigative Support Unit	County Sheriff's Office
Deputy Sheriff	County Sheriff's Office
Detective	County Sheriff's Office
Detective Sergeant	County Sheriff's Office
Detective/Task Force	County Sheriff's Office
Division Commander	County Sheriff's Office
Drug Task Force (2)	County Sheriff's Office
Major Crimes Supervisor	County Sheriff's Office
Operations Captain	County Sheriff's Office
Sheriff (5)	County Sheriff's Office
Undersheriff (2)	County Sheriff's Office
Administrative Sergeant	Regional Drug Task Force
Town Marshal	Town Marshal's Office
Task Force Supervisor	WSP/WestNet

Child Protective Services (CPS)

JOB TITLE	EMPLOYING AGENCY/ORGANIZATION
Area Administrator	DCFS DSHS
CPS Investigator	DCFS
CPS Investigator, Social Worker 3 (2)	DSHS, DCFS
CPS Social Worker	DCFS
CPS Social Worker 3	DSHS DCFS
CPS Social worker 4	CPS
CPS Supervisor (4)	WA
CPS Supervisor, Social Worker 4 (3)	DCFS
DEC Investigator, CPS Social Worker	CPS, Regional Drug Task Force
Intake Supervisor (2)	DCFS
Interim Area Administrator	DCFS
Supervisor DCFS Office, Member of Meth Action Team, Social Worker 4	DCFS

Medical

JOB TITLE	EMPLOYING AGENCY/ORGANIZATION
ER Department Director	Community Hospital
Director of Health	County Health District
Associate Director Patient Clinical Services	County Healthcare
CPS Social Worker	CPS, Regional Drug Task Force
Family Physician	Family Practice
Medical Director	Family Practice
Emergency Dept. Manager	General Hospital
Clinical Manager	Hospital
CNO	Hospital
Director of Nursing	Hospital
ER Coordinator	Hospital
Clinical Social Work Coordinator	Medical Center
Director, Emergency Trauma Services	Medical Center
Family Physician	Medical Center
Medical Director	Medical Services
Program Supervisor/Child Interviewer	Medical Services
Pediatrician	Private Practice/DCFS Medical Consultant
Assistant Director of Nursing	Public Hospital District
ER Department Nurse Manager	Regional Hospital
Medical Director, Child Abuse Consultant	University

Prosecution

JOB TITLE	EMPLOYING AGENCY/ORGANIZATION
Chief Criminal Deputy Prosecuting Attorney and Senior Deputy Prosecuting Attorney	County Prosecutor's Office
Deputy Prosecuting Attorney (2)	County Prosecutor's Office
Deputy Prosecutor Narcotics	County Prosecutor's Office
Prosecuting Attorney (6)	County Prosecutor's Office
Prosecutor (8)	County Prosecutor's Office
Senior Deputy Prosecuting Attorney (2)	County Prosecutor's Office
Supervising Attorney, Drug Unit	County Prosecutor's Office

APPENDIX B: Response Counts and Percentages by Matrix Area

Law Enforcement

"For drug-endangered children in your jurisdiction, **is there a law enforcement procedure in place** for the following?"

Procedure / County Size	Does law enforcement have a procedure in place for the following controlled substances:									
	Meth (child abused or neglected)		**Meth** (child directly exposed)		**Illicit Drugs**		**Alcohol**		**Other drugs** (e.g., prescription drugs)	
Take child into protective custody										
All	**27 of 29**	**93%**	**26 of 29**	**90%**	**22 of 28**	**79%**	**20 of 28**	**71%**	**21 of 28**	**75%**
Small*	13 of 14	93	13 of 14	93	12 of 13	92	12 of 13	92	12 of 13	92
Medium*	6 of 7	86	5 of 7	71	3 of 7	43	3 of 7	43	3 of 7	43
Large*	8 of 8	100	8 of 8	100	7 of 8	87	5 of 8	62	6 of 8	75
Release child to family or neighbors										
All	**13 of 28**	**46%**	**11 of 28**	**39%**	**12 of 27**	**44%**	**11 of 27**	**41%**	**12 of 27**	**44%**
Small	4 of 14	29	4 of 14	29	4 of 13	31	4 of 13	31	4 of 13	31
Medium	3 of 6	50	2 of 6	33	2 of 6	33	2 of 6	33	2 of 6	33
Large	6 of 8	75	5 of 8	62	6 of 8	75	5 of 8	62	6 of 8	75
Transfer custody to Child Protective Services										
All	**27 of 28**	**96%**	**27 of 28**	**96%**	**23 of 27**	**85%**	**21 of 27**	**78%**	**22 of 27**	**82%**
Small	12 of 13	92	12 of 13	92	11 of 12	92	11 of 12	92	11 of 12	92
Medium	7 of 7	100	7 of 7	100	5 of 7	71	5 of 7	71	5 of 7	71
Large	8 of 8	100	8 of 8	100	7 of 8	88	5 of 8	62	6 of 8	75
Collect biological samples for evidence: within ___ hrs										
All	**13 of 29**	**45%**	**15 of 28**	**54%**	**7 of 27**	**26%**	**7 of 27**	**26%**	**6 of 27**	**22%**
Small	3 of 14	21	5 of 13	38	2 of 12	17	2 of 12	17	2 of 12	17
Medium	4 of 7	57	4 of 7	57	2 of 7	29	2 of 7	29	2 of 7	29
Large	6 of 8	75	6 of 8	75	3 of 8	37	3 of 8	37	2 of 8	25
Retrieve and submit biological samples: to Washington State Patrol toxicology lab										
All	**12 of 26**	**46%**	**14 of 27**	**52%**	**8 of 25**	**32%**	**10 of 25**	**40%**	**8 of 25**	**32%**
Small	4 of 11	36	6 of 12	50	4 of 10	40	5 of 10	50	4 of 10	40
Medium	3 of 7	43	3 of 7	43	1 of 7	14	1 of 7	14	1 of 7	14
Large	5 of 8	62	5 of 8	62	3 of 8	37	4 of 8	50	3 of 8	37
Retrieve and submit biological samples: to non-state lab: _____										
All	**5 of 23**	**22%**	**5 of 23**	**22%**	**4 of 22**	**18%**	**3 of 22**	**14%**	**4 of 22**	**18%**
Small	2 of 11	18	2 of 11	18	2 of 10	20	2 of 10	20	2 of 10	20
Medium	1 of 5	20	1 of 5	20	0 of 5	0	0 of 5	0	0 of 5	0
Large	2 of 7	29	2 of 7	29	2 of 7	29	1 of 7	14	2 of 7	29
Document other environmental dangers that could put children in danger, including access to drugs, chemicals and drug paraphernalia, weapons, pornography										
All	**23 of 27**	**85%**	**23 of 27**	**85%**	**20 of 26**	**77%**	**18 of 26**	**69%**	**20 of 26**	**77%**
Small	10 of 12	83	10 of 12	83	10 of 11	91	10 of 11	91	10 of 11	91
Medium	5 of 7	71	5 of 7	71	3 of 7	43	3 of 7	43	3 of 7	43
Large	8 of 8	100	8 of 8	100	7 of 8	87	5 of 8	62	7 of 8	87

*Caution: Percentages are based on small sample sizes.

Law Enforcement (cont.)

Procedure / County Size	Does law enforcement have a procedure in place for the following controlled substances: **Meth** (child abused or neglected)		**Meth** (child directly exposed)		**Illicit Drugs**		**Alcohol**		**Other drugs** (e.g., prescription drugs)	
Document other conditions related to care of the child: food quantity and quality										
All	**23 of 28**	**82%**	**23 of 28**	**82%**	**20 of 27**	**74%**	**17 of 27**	**63%**	**19 of 27**	**70%**
Small*	11 of 13	85	11 of 13	85	11 of 12	92	10 of 12	83	10 of 12	83
Medium*	5 of 7	71	5 of 7	71	3 of 7	43	3 of 7	43	3 of 7	43
Large*	7 of 8	88	7 of 8	88	6 of 8	75	4 of 8	50	6 of 8	75
Document other conditions related to care of the child: sanitary conditions										
All	**23 of 28**	**82%**	**23 of 28**	**82%**	**20 of 27**	**74%**	**17 of 27**	**63%**	**19 of 27**	**70%**
Small	11 of 13	85	11 of 13	85	11 of 12	92	10 of 12	83	10 of 12	83
Medium	5 of 7	71	5 of 7	71	3 of 7	43	3 of 7	43	3 of 7	43
Large	7 of 8	88	7 of 8	88	6 of 8	75	4 of 8	50	6 of 8	75
Document other conditions related to care of the child: sleeping conditions										
All	**21 of 28**	**75%**	**21 of 28**	**75%**	**18 of 27**	**67%**	**16 of 27**	**59%**	**17 of 27**	**63%**
Small	9 of 13	69	9 of 13	69	9 of 12	75	9 of 12	75	9 of 12	75
Medium	5 of 7	71	5 of 7	71	3 of 7	43	3 of 7	43	3 of 7	43
Large	7 of 8	88	7 of 8	88	6 of 8	75	4 of 8	50	5 of 8	62
Document other conditions related to care of the child: evidence of injuries										
All	**24 of 28**	**86%**	**24 of 28**	**86%**	**21 of 27**	**78%**	**19 of 26**	**73%**	**21 of 27**	**78%**
Small	11 of 13	85	11 of 13	85	11 of 12	92	11 of 12	92	11 of 12	92
Medium	6 of 7	86	6 of 7	86	4 of 7	57	4 of 7	57	4 of 7	57
Large	7 of 8	88	7 of 8	88	6 of 8	75	4 of 7	57	6 of 8	75
Document other conditions related to care of the child: cleanliness and dress										
All	**22 of 28**	**79%**	**22 of 28**	**79%**	**19 of 27**	**70%**	**17 of 27**	**63%**	**19 of 27**	**70%**
Small	10 of 13	77	10 of 13	77	10 of 12	83	10 of 12	83	10 of 12	83
Medium	5 of 7	71	5 of 7	71	3 of 7	43	3 of 7	43	3 of 7	43
Large	7 of 8	88	7 of 8	88	6 of 8	75	4 of 8	50	6 of 8	75
Document other conditions related to care of the child: other signs of neglect										
All	**24 of 29**	**83%**	**24 of 29**	**83%**	**21 of 28**	**75%**	**19 of 28**	**68%**	**21 of 28**	**75%**
Small	12 of 14	86	12 of 14	86	12 of 13	92	12 of 13	92	12 of 13	92
Medium	5 of 7	71	5 of 7	71	3 of 7	43	3 of 7	43	3 of 7	43
Large	7 of 8	88	7 of 8	88	6 of 8	75	4 of 8	50	6 of 8	75
Conduct interviews with neighbors, school officials and others who can provide information about the care the child is receiving										
All	**24 of 29**	**83%**	**24 of 29**	**83%**	**20 of 28**	**71%**	**19 of 28**	**68%**	**20 of 28**	**71%**
Small	12 of 14	86	12 of 14	86	12 of 13	92	12 of 13	92	12 of 13	92
Medium	5 of 7	71	5 of 7	71	3 of 7	43	3 of 7	43	3 of 7	43
Large	7 of 8	88	7 of 8	88	5 of 8	62	4 of 8	50	5 of 8	62

*Caution: Percentages are based on small sample sizes.

Briefly describe your procedures:

- They are covered under our Drug Endangered Children Protocol.
- […] County has developed a DEC protocol addressing the needs of children exposed to meth—particularly meth labs. Partners include: […] county sheriff, […] drug task force, Child Protective Services (CPS), […] health systems, Child Abuse Intervention Center, (multi-care medical/social services clinic)
- Via Drug Endangered Children protocol established in 2002. This is a partnership between law enforcement, CPS, prosecutor, health department, and Sexual Assault Center
- […] County sheriff's office has implemented a protocol for responding to and investigating DEC cases. We train our first responders on how to handle such cases as well as coordinate with CPS, health department, and other agencies involved in the aftermath of such a case. Training covering the above issues is given to first responders during annual in-service training. We have open, continual communication with our local CPS office on such cases. We could use some assistance in garnering more support and coordination from local doctors and the emergency room when medical support is needed for the children removed from the situation.
- […] County does not have a formal policy regarding these issues. Basic documentation of all conditions and actions are in place.
- The […] regional drug task force has a full time CPS investigator assigned to the office to work cases involving children and drug endangerment. Detectives at the [regional drug task force] include the CPS investigator on all cases where children are present. Having the CPS investigator in the mix with law enforcement has allowed for an open line of communication.
- […] County has adopted the DEC Investigative Handbook devised and designed by the […] County Meth Action Team. The […] County Sheriff's Department has adopted it as policy but training in the area has not yet taken place.
- Conduct investigation, as we would do any investigation. Involve CPS if children involved or endangered.
- If child is in danger, child will be taken into protective custody and turned over to CPS.
- We work with CPS to assess risks involving children.
- The health department or the authorities with the state Child Protective Service answer this best. Law enforcement answers are shown above.
- The [county sheriff's office's] Special Assault Unit (SAU) sends out two detectives on DEC cases with our narcotics detectives. SAU handles the DEC case and the narcotics detectives take the lead on the meth lab. The two cases are presented together as one joined case to the […] Prosecutor's Office for filing. CPS is a partner in this program offering child welfare to come to the scene during our investigations. See attached policy and standard operating procedure.
- Any child found in a meth lab will be taken to the local hospital for evaluation. CPS is notified immediately for assistance. The child is placed. With any child found in a residence where drug dealing is taking place, the child is placed with CPS. Any child found to be neglected is placed with CPS.
- Law enforcement works together with CPS and other agencies to assure that children are protected!
- We work hand in hand with all other agencies, including CPS, prosecution, fire, Emergency Medical Services, etc. When we deal with children in a drug setting, especially meth, we have a procedure set up with all of the agencies on dealing with the children. Once we have the scene secure, the children are turned over to CPS.

- As you can see by the attached protocol we have included all agencies within the county to include all (4) law enforcement agencies, CPS, (2) hospitals, the prosecutor, health department, and our Department of Community Development. Each play a role or are notified when DEC are involved. See protocol for details.
- If we find a child who is [in imminent] danger of neglect or abuse, we will take the child into protective custody and turn custody over to CPS. If the child has been exposed to meth or a meth lab, we will also seize the outer clothing of the child, as well as collect hair pluckings from the child. Also gather bedding and measure the distance from the child to the drug and gather favorite toys.
- Services are provided through a collaborative effort between law enforcement, [Medical], [Community Faith-Based] Services, CPS and other community agencies. Referrals to the organization can come through law enforcement or through social services.
- Law enforcement locates a DEC child and conducts a preliminary investigation. If sufficient cause to remove a child is found, the DEC-CPS worker at the narcotics unit is called. He responds, documents conditions, interviews child, transports child to medical facility, collects samples, and arranges placement in foster care or with other non-addictive relative. He prepares report and shares it with law enforcement. He will also assist with custody proceedings to ensure long-term stable placement.
- We respond—determine if child needs protective custody—or if we stand by until CPS can arrive on the scene. Often (someone?) will take the children to the sheriff's office to meet CPS.
- When children are discovered in the presence of a meth lab, the protocol is activated. Numerous agencies are involved including Emergency Medical Services, CPS, prosecuting attorney, and law enforcement.
- Law enforcement works closely with CPS, the prosecutor, and other social service organizations to provide the best possible services for the children in need of assistance. Any time a case rises to the level of protective custody, our county service agencies uses a TEAM approach to best mitigate the situation.

Are there differences between your procedures for meth and your procedures when drugs other than meth are involved?

Number of counties responding "Yes"

All counties	12 of 24	(50%)
Small	3 of 11	
Medium	3 of 5	
Large	6 of 8	

If yes, please describe:

- The child is taken to the hospital for decontamination in the event they are exposed to production of meth.
- The protocol covers meth labs only.
- To my knowledge, the only specific "protocol" that exists which includes this level of partnership and detail is for children affected by meth.
- Children still connected with CPS; however, no protocol for further action is in place as for meth cases.
- There seems to be more awareness when dealing with meth, hence more thorough investigation. It has been very difficult to get local doctors to commit to stating what medical effects drug exposure has caused to a child. This has made it difficult for us to "make a case" to provide the prosecutor's

office. Unless we have a clear, specific "manufacturing with a child present" we are having a hard time making a strong enough case to have the parent prosecuted.

- In the area of alcohol or prescription drugs, LEA/CPS may, in their best judgment, leave a child someplace other than in foster care.
- Only if lab or dumpsite.
- The DEC statutes help us by defining that this is a clear-cut crime by having children exposed to meth labs/meth chemicals. We have SAU detectives respond to take the children into protective custody, document the crime scene and collect evidence. With other drugs, criminal statutes are not present to clearly identify that crime is taking place, i.e., crack babies exposed before birth.
- Yes. When meth is involved, we have a procedure set up with CPS to take care of the children. All other drugs are handled case by case. The toxic nature of meth creates an entirely different atmosphere on how we deal with a scene, especially if there are signs that a lab has been or is present in a residence.
- In meth cases we would gather child's hair pluckings, favorite toys, and take measurements from child to drugs. Our protocol does not address other drugs specifically.
- This usually involves a meth lab case in which law enforcement must collect the information on living conditions, possibly with the assistance of environmental health specialists.
- There is no specific protocol in place for other drugs, but it is common that CPS is notified whenever children are present during a drug arrest of any sort.
- NO, but there could be if there are decontamination or direct lab/meth exposure issues.

Are there differences between your procedures for when the issue is abuse/neglect due to the caregiver's drug use as opposed to the children's direct exposure to drugs?

Number of counties responding "Yes"

All counties	13 of 24	(54%)
Small	3 of 11	
Medium	2 of 5	
Large	8 of 8	

If yes, please describe:

- There are mandatory procedures required when a meth lab is involved. If it is just meth or other drugs it is left to the officer and situation.
- The comprehensiveness of response and involvement by all key partners is greater when children have been directly exposed.
- Above-described protocol is for children EXPOSED to meth manufacturing. Absent this exposure, appropriate neglect/abuse charges are pursued.
- No set protocol for this specific issue rather the case is usually co-investigated with CPS to determine whether the child should be removed from the parents'/guardian's care.
- In the area of investigation. Many or all of the problems involving the home environment may not exist, so in that respect, the [discretion] of the investigator/s would be honored (i.e., an abusive alcoholic parent).
- Only if lab or dumpsite.
- Recreational drug users who have children are often not the suspects of crimes unless we can prove that the child is in clear and significant danger (rather than just exposed).

- Yes. For law enforcement the situation is a lot more serious if the child has been directly exposed to drugs, especially with meth.
- In regards to meth there are differences. No other drug. Differences are described above.
- These cases usually do not involve a CPS call out or an investigation that is as in-depth unless there are signs of physical or sexual abuse.
- Except in the case of a meth lab, children are turned over to CPS if no other family caregiver is available and the child does not need medical attention. In the case of family placement, CPS is notified for follow-up.
- The [regional drug task force] policy only addresses children that are exposed to a drug environment and not a victim of neglect due to drug use or abuse.
- The evidence that will be collected at the scene would be different. In a direct exposure incident, we may take samples of carpeting, bedding, furniture fabric, etc. In a neglect due to caregivers use, those samples may not be necessary, but each incident is different. A urine/biological sample may not be collected from the victim, either.

Child Protective Services (CPS)

For drug-endangered children in your service area, is there a CPS procedure in place for the following actions?

Procedure / County Size	Does CPS have a procedure in place for the following controlled substances:									
	Meth (child abused or neglected)		**Meth** (child directly exposed)		**Illicit Drugs**		**Alcohol**		**Other drugs** (e.g., prescription drugs)	
Transfer custody from law enforcement to CPS: at the scene that law enforcement is responding to										
All	**22 of 28**	**79%**	**22 of 28**	**79%**	**19 of 27**	**70%**	**18 of 27**	**67%**	**17 of 27**	**63%**
Small*	9 of 14	64	9 of 14	64	8 of 13	61	8 of 13	61	7 of 13	54
Medium*	5 of 6	83	5 of 6	83	4 of 6	67	4 of 6	67	4 of 6	67
Large*	8 of 8	100	8 of 8	100	7 of 8	88	6 of 8	75	6 of 8	75
Transfer custody from law enforcement to CPS: at other locations										
All	**21 of 28**	**75%**	**21 of 28**	**75%**	**19 of 27**	**70%**	**17 of 27**	**63%**	**18 of 27**	**67%**
Small	10 of 14	71	10 of 14	71	9 of 13	69	9 of 13	69	8 of 13	62
Medium	4 of 6	67	4 of 6	67	4 of 6	67	3 of 6	50	4 of 6	67
Large	7 of 8	88	7 of 8	88	6 of 8	75	5 of 8	62	6 of 8	75
Locate other dependent children not at the scene										
All	**19 of 28**	**68%**	**19 of 28**	**68%**	**16 of 26**	**62%**	**16 of 26**	**62%**	**13 of 25**	**52%**
Small	8 of 14	57	8 of 14	57	8 of 13	62	8 of 13	62	5 of 12	42
Medium	4 of 6	67	4 of 6	67	3 of 5	60	3 of 5	60	3 of 5	60
Large	7 of 8	88	7 of 8	88	5 of 8	62	5 of 8	62	5 of 8	62
Procedures for immediate care services: decontamination and/or transport to medical care										
All	**15 of 28**	**54%**	**15 of 28**	**54%**	**9 of 26**	**35%**	**8 of 26**	**31%**	**8 of 26**	**31%**
Small	6 of 14	43	5 of 14	36	4 of 13	31	3 of 13	23	3 of 13	23
Medium	4 of 6	67	5 of 6	83	4 of 6	67	4 of 6	67	4 of 6	67
Large	5 of 8	62	5 of 8	62	1 of 7	14	1 of 7	14	1 of 7	14
Procedures for immediate care services: collect biological samples for evidence within ___ hrs.										
All	**8 of 28**	**29%**	**9 of 28**	**32%**	**7 of 27**	**26%**	**4 of 27**	**15%**	**5 of 27**	**18%**
Small	3 of 14	21	3 of 14	21	2 of 13	15	2 of 13	15	2 of 13	15
Medium	2 of 6	33	2 of 6	33	2 of 6	33	0 of 6	0	1 of 6	17
Large	3 of 8	37	4 of 8	50	3 of 8	37	2 of 8	25	2 of 8	25
Procedures for immediate care services: transport child to receiving home										
All	**22 of 27**	**82%**	**22 of 27**	**82%**	**20 of 26**	**77%**	**20 of 26**	**77%**	**19 of 26**	**73%**
Small	10 of 14	71	10 of 14	71	9 of 13	69	9 of 13	69	8 of 13	62
Medium	5 of 6	83	5 of 6	83	5 of 6	83	5 of 6	83	5 of 6	83
Large	7 of 7	100	7 of 7	100	6 of 7	86	6 of 7	86	6 of 7	86
Conduct initial interview with child										
All	**23 of 27**	**85%**	**23 of 27**	**85%**	**19 of 26**	**73%**	**19 of 26**	**73%**	**18 of 26**	**69%**
Small	11 of 14	79	11 of 14	79	10 of 13	77	10 of 13	77	9 of 13	69
Medium	5 of 6	83	5 of 6	83	4 of 6	67	4 of 6	67	4 of 6	67
Large	7 of 7	100	7 of 7	100	5 of 7	71	5 of 7	71	5 of 7	71
Complete initial placement assessment										
All	**21 of 26**	**81%**	**21 of 26**	**81%**	**19 of 25**	**76%**	**19 of 25**	**76%**	**18 of 25**	**72%**
Small	10 of 14	71	10 of 14	71	9 of 13	69	9 of 13	69	8 of 13	62
Medium	5 of 6	83	5 of 6	83	5 of 6	83	5 of 6	83	5 of 6	83
Large	6 of 6	100	6 of 6	100	5 of 6	83	5 of 6	83	5 of 6	83

*Caution: Percentages are based on small sample sizes.

Briefly describe your procedures:

- 1) Community child protection team staffing, 2) multi-disciplinary meetings with treatment staff.
- CPS has procedures for all of the categories listed above but they are not specific to drug endangered children. Procedures are for abused neglected children and DEC would fall into that.
- CPS processes referrals and completes an assessment of risk. If there are serious concerns a safety plan/service plan will be developed. If the parents do not comply, a dependency petition may be filed. In very serious cases a dependency petition will immediately be filed.
- CPS takes referrals and investigates all allegations of abuse and neglect that involve clear risk to children by their parent or legal caretaker. This would include any abuse/neglect as a result of drug usage and/or direct contact with drug related corrosive substances.
- From 2/01 to 4/04 I was assigned to the […] county narcotics task force and would remove children from drug-endangered homes. The children would be medically evaluated at a hospital. Currently I'm not sure where the children are being evaluated if they are removed from the drug home. With regards to other drugs, the children weren't evaluated medically immediately. The children were either placed with a relative or a foster home, and were told that the children needed a well child check.
- Full time CPS worker at the drug task force—CPS worker works with three drug task forces.
- Generally for those cases in which it is known that children are endangered, i.e. police are doing a raid on a known drug house. If they know there are children involved, they will call us to meet them on the scene. If placement or medical care is needed, law enforcement will place the children in protective custody and do a Transfer of Custody to the Department. Placement and medical care or decontamination is arranged by the social worker. If we discover drug issues in the course of an investigation, and a crime may have been committed, we would report this to the police who will participate as needed in further investigation. We can also ask for them to do a Protective Custody Hold on a child, or we can file a Dependency Petition and get a court order for the removal of a child from his home. The placement and medical piece remain the same.
- Have begun Meth-Action Teams with local organizations and community members; work closely with law enforcement when illegal substances are suspected.
- […] County has no written protocol for DEC involved in meth labs. There are the WACs that govern the procedure for screening in and investigating allegations of abuse and neglect that are the result of substance abuse and in providing ongoing child welfare services to child and family.
- Medical providers, law enforcement, juvenile court system, family preservation, etc.
- Placement services such as foster homes—social work services available 24/7, which include relative placement search. Other services such as counseling, etc. are contracted.
- Protocol in place with CPS and the child abuse intervention center/law enforcement for children at eminent harm due to drugs. Agency is in process of finalizing DEC protocol.
- […] County has a DEC team; included is CPS, law enforcement (county/city), [medical provider], prosecutor, [faith-based] Social Service, education ([medical provider] provides medical exams and developmental).
- The primary function of CPS is to collaborate with law enforcement prior to, during, and after a drug interdiction that may involve children; to provide supporting information before; to take custody and protect children; to facilitate placement; to insure the caregiver is appropriate; and to cooperate with law enforcement and prosecution to gather evidence relating to children, including biological samples and a physical survey of the environment if possible.
- There has been a protocol that has been inactive. Situations are responded to on a case-by-case basis. Public health, medical, substance abuse, and mental health treatment resources are utilized

as needed to assess the risk/impact on children, and to intervene.

- Through investigations, collateral contacts with law enforcement, subject interviews, medical exams, referrals to appropriate services, and follow up.
- We do not have a specific procedure in place for DEC. The regular protocol that we follow for any placement and transfer of custody is what is done in the very few times we even get referrals for placements from drug activities.
- We use common sense procedures rather than standard operating procedures, which would be better. We don't have equipment for decontamination.

Are there differences between your procedures for meth and your procedures when drugs other than meth are involved?

Number of counties responding "Yes"

All counties	8 of 22	(36%)
Small	4 of 11	
Medium	3 of 5	
Large	1 of 6	

If yes, please describe:

- The only difference is that we advised foster parents of the meth issue and the need for the children to be immediately showered. Also we do not take any belongings of the children from the child's home. The foster parents are advised to bag the clothes that the children were wearing and dispose of them.
- Generally there is less of a response if the parent is involved in marijuana use only, as there does not appear to be such a severe impact on their ability to parent.
- Children removed from a home where they have been exposed to the chemical contaminates involved with meth production need to undergo meth decontamination. All children placed in foster care are provided with a medical examination at the earliest time possible.
- For meth, the children used to be evaluated at a hospital. They would screen the children medically and also do a urine analysis (UA). This information would be provided to law enforcement and the prosecutor's office in cases of criminal charges being filed.
- Meth can contaminate in a passive way, and leaves the system in a relatively short amount of time. This creates a more urgent need for medical attention and testing to determine the course of treatment necessary for the child. The child's clothing and possessions may be contaminated, creating a hazard for first responders and placement resources. Children of meth users are often subject to serious neglect as parents will not or cannot provide for basic needs while using meth.
- There would be more caution regarding exposure to chemicals if manufacturing is taking place. Children would be checked out by Emergency Medical Response, and possibly hospital if needed/recommended.
- Immediate medical exam, collateral contact with law enforcement for information sharing/gathering. We have one worker assigned for meth cases, as he has extensive training and experience with meth exposure.

Are there differences between your procedures for when the issue is abuse/neglect due to the caregiver's drug use as opposed to the children's direct exposure to drugs ?

Number of counties responding "Yes"

All counties	10 of 20	(50%)

Small	3 of 10
Medium	4 of 4
Large	3 of 6

If yes, please describe:

- The agency has more of an ability to intervene if the issues are related to abuse and neglect rather than exposure to drugs. Often exposure to drugs is part of a neglectful situation, and the possibility that a child might ingest drugs or touch contaminated materials due to lax supervision is part of the risk.
- Direct exposure to drugs, especially the toxic chemicals used in meth, constitutes a medical emergency; whereas neglect due to the use of any drugs does not constitute an emergency unless the neglect is currently putting the child at imminent risk of serious injury or harm. Children neglected due to the use of certain drugs are more likely to be able to remain in their own home with services being provided than those who were exposed to meth in their own home.
- Direct exposure would entail an immediate exam.
- If the children are directly affected by drug exposure, they have an immediate medical screen.
- […] County has a protocol in place for a child's direct exposure to drugs.
- Exposure to drugs versus a neglected environment due to drug use would generate different responses. (Example: the first situation—we would seek immediate medical attention.)
- There may be case-by-case variance. The main concern with direct exposure versus neglect relating to drugs would be toxicity; so medical assays may be more likely.
- We may or may not be notified if the issue is direct exposure. If there are no allegations of child abuse or neglect, the information needs to be evaluated based upon the level of risk posed to the child(ren).
- No, exposure is considered neglect.
- No, if a child is found to be in a meth lab home, and law enforcement deems it necessary to place a child because they see a child at imminent risk of harm, the child will be placed. There are no protocols for decontamination or collection of biological samples unless it's part of the law enforcement procedures.
- No, the only difference there might be is that we would be even more cautious with children being removed from a home where meth was being cooked. We would be possibly more diligent in getting children bathed, and no belongings from their homes to come with them.

Medical Services

For drug-endangered children in your jurisdiction, is there a medical procedure in place for the following actions?

Procedure / County Size	Does Medical Services have a procedure in place for the following controlled substances:									
	Meth (child abused or neglected)		**Meth** (child directly exposed)		**Illicit Drugs**		**Alcohol**		**Other drugs** (e.g., prescription drugs)	
Conduct medical exam of child: within 24 hours if illness is suspected										
All	**18 of 27**	**67%**	**19 of 26**	**73%**	**10 of 23**	**43%**	**11 of 24**	**46%**	**9 of 22**	**41%**
Small*	7 of 13	54	6 of 12	50	4 of 11	36	4 of 11	36	3 of 10	30
Medium*	4 of 6	67	5 of 6	83	2 of 5	40	3 of 6	50	2 of 5	40
Large*	7 of 8	88	8 of 8	100	4 of 7	57	4 of 7	57	4 of 7	57
Conduct medical exam of child: within 7-14 days if no illness is apparent										
All	**11 of 25**	**44%**	**11 of 25**	**44%**	**5 of 21**	**24%**	**6 of 22**	**27%**	**5 of 21**	**24%**
Small	1 of 11	9	1 of 11	9	1 of 10	10	1 of 10	10	1 of 10	10
Medium	3 of 6	50	3 of 6	50	1 of 4	25	2 of 5	40	1 of 4	25
Large	7 of 8	88	7 of 8	88	3 of 7	43	3 of 7	43	3 of 7	43
Collect biological samples for evidence: within ___ hrs.										
All	**11 of 24**	**46%**	**14 of 24**	**58%**	**6 of 23**	**26%**	**6 of 23**	**26%**	**5 of 23**	**22%**
Small	5 of 12	42	5 of 12	42	3 of 11	27	3 of 11	27	3 of 11	27
Medium	3 of 5	60	4 of 5	80	1 of 5	20	1 of 5	20	1 of 5	20
Large	3 of 7	43	5 of 7	71	2 of 7	29	2 of 7	29	1 of 7	14
Send biological samples: to Washington State Patrol toxicology lab										
All	**10 of 25**	**40%**	**10 of 25**	**40%**	**4 of 24**	**17%**	**1 of 24**	**4%**	**1 of 24**	**4%**
Small	3 of 11	27	3 of 11	27	1 of 10	10	0 of 10	0	0 of 10	0
Medium	4 of 6	67	4 of 6	67	2 of 6	33	1 of 6	17	1 of 6	17
Large	3 of 8	37	3 of 8	37	1 of 8	13	0 of 8	0	0 of 8	0
Send biological samples: to non-state lab: _____										
All	**5 of 18**	**28%**	**5 of 18**	**28%**	**4 of 17**	**24%**	**4 of 17**	**24%**	**3 of 17**	**18%**
Small	3 of 10	30	3 of 10	30	3 of 9	33	3 of 9	33	2 of 9	22
Medium	0 of 3	0	0 of 3	0	0 of 3	0	0 of 3	0	0 of 3	0
Large	2 of 5	40	2 of 5	40	1 of 5	20	1 of 5	20	1 of 5	20
Conduct Early Periodic Screening, Detection and Treatment (EPSDT) exam within 1 month of placement.										
All	**8 of 26**	**31%**	**8 of 24**	**33%**	**5 of 24**	**21%**	**6 of 22**	**27%**	**6 of 22**	**27%**
Small	1 of 12	8	1 of 11	9	1 of 11	9	1 of 10	10	1 of 10	10
Medium	2 of 6	33	2 of 5	40	0 of 5	0	1 of 5	20	1 of 5	20
Large	5 of 8	62	5 of 8	62	4 of 8	50	4 of 7	57	4 of 7	57

*Caution: Percentages are based on small sample sizes.

Briefly describe your procedures:

- Acute situations requiring immediate evaluation and treatment are handled at the Emergency Department. Pediatric medical staff at designated clinics provides non-urgent and follow-up care.
- Basically offer access to evaluation work in conjunction with Child Protective Services (CPS).
- Children can be seen for acute intoxication or medical symptoms at [Hospital 1] or [Hospital 2] or [Hospital 3]. Medical exams within 7-10 days are available at [Hospital 1] either [central] or south, but not often requested by CPS. A physician in the community usually sees children.
- ER, physician office.
- It's case dependent. Usually referred to CPS or social services if problems identified.
- Children in our county who have been endangered by the drug use of their parent and/or caretaker are identified as soon as a referral is made to either law enforcement or CPS. If the children have needs that are acute (meth lab and exposure) they are immediately identified and Emergency Medical Services (EMS) is contacted. EMS is well versed in the procedures necessary and will respond according to the need. That may be removing the child's clothing and washing them and then providing them with new clothes to wear. If it is determined by EMS, the child can be transported to one of our medical centers. We have worked with the head of our EMS and are in the process of planning further training for ER staff.

  Children identified as DEC who are not in need of immediate care, are referred to a hospital-based community alcohol center to be seen by one of our medical staff. We have two pediatricians, two nurse practitioners, and an ER nurse. All of our medical staff have been treating child abuse cases for years and have all been trained in the procedures for our DEC kids. Children receive a full medical exam, including hearing and vision screening and head circumference. These children are screened for any evidence of abuse and/or neglect. They are then referred to one of our nurse practitioners to have the Battelle evaluation.

  We are very fortunate to have a DEC Case Coordinator who works for us and is housed in the intake unit at CPS. He is often present when law enforcement goes into the home and can immediately begin the process for these children. He follows the children through the system and ensures that they are seen by medical staff and evaluated in a timely manner. He is often present when/if the children are placed out of the home and will begin working with the receiving home, foster home, and social worker to make the necessary referrals for medical care.

  If it is determined that the children are in need of further medical care, they can return to our clinic for follow-up, or they can then be sent to their own medical provider. Our doctors work with CPS and with families to ensure that all children have a "medical home."

  We have a doctor who is our lead researcher. She has one research assistant. Together they collect data and provide a detailed report. The doctor submitted our research project during the first year and we were so fortunate to have it published.
- No specific pediatric protocols currently in place— individual cases handled on case-by-case basis by patient's medical doctor. Compass mental health available to Division of Social and Health Services (DSHS) families.
- None
- Our policy would be to report to CPS whenever abuse/neglect is suspected.
- Protocol to evaluate kids especially for symptoms of meth or chemicals BUT specifically for abuse, neglect, immunization delay, etc.
- Task force currently being formed—policies and procedures in medical staff for review and acceptance.
- The Meth Action Team has been very active in eliciting participation from the local hospital, local

public health, local pediatricians, and the [military] hospital regarding the medical aspect of these patients.

- There are no specific written procedures in place for these things. Many of the above tasks often do happen as a regular part of patient care. However, there is no formal mechanism to trigger the tasks, and they could conceivably not happen. Currently hospital staff consult with pediatricians and do the best they can, given their combined knowledge to meet the needs of drug-endangered children.
- We are a hospital and when signs of drug-endangered children are identified, we test and refer to our local CPS program. We do not have written policies currently.
- We don't have any policies/procedures set up specifically for children relating to meth use and its exposure. We would treat them like all other potential "poisonings"—we could contact Poison Control for guidance on known exposed substances.
- We have forensic staff that come in and assist in the collection of forensic evidence in children suspected of being in meth labs or are suspected in child abuse cases.

Are there differences between your procedures for meth and your procedures when drugs other than meth are involved?

Number of counties responding "Yes"

All counties	11 of 22	(45%)
Small	3 of 11	
Medium	2 of 5	
Large	5 of 6	

If yes, please describe:

- All patients are assessed at Triage in the Emergency Department (ED) and provided with a Medical Screening Exam by the ED Physician. If the physician suspects there may be substance abuse, the physician orders toxicology screens to determine the patient's exposure. Children presenting with a CPS worker from a suspected drug contaminated environment are treated with the DEC protocol adopted by [Medical Center]. The CPS worker obtains the lab results, which are reported to the court system.
- Biological samples from meth cases are forwarded to the Washington State Patrol Toxicology Lab. All other drugs can be handled at [Hospital]. In cases involving evidentiary biological specimens used in legal proceedings, those samples are forwarded to the state lab for processing.
- For newborns, we test meconium (Ed note: first feces/stool)
- Awareness of toxins used in meth production that might impact child's health.
- No plan for others.
- We have a written protocol for dealing with children that may have exposure to meth. Including standing orders. For other cases of neglect or abuse, we rely on the ER MD to order appropriate labs, and staff to document and assess sustained injuries.
- If child is out of a meth lab, hospital staff decontaminate the children at arrival.

- Children who are referred to CPS are most often referred because of neglect or abuse issues. It is only after an intervention that CPS, and law enforcement determines that the children have been endangered by drugs. Meth cases are handled differently because of the extreme toxicity of the drug and its ability to permeate the entire area inhabited by the child. Also, its ability to take over the lives of the caretakers. Our goal is to meet the child's medical (abuse/neglect) needs immediately and allow CPS and law enforcement to determine what direction the case will take.

Are there differences between your procedures for when the issue is abuse/neglect due to the caregiver's drug use as opposed to the children's direct exposure to drugs?

Number of counties responding "Yes"

All counties	7 of 20	(35%)
Small	3 of 11	
Medium	1 of 4	
Large	3 of 5	

If yes, please describe:

- As described above, a CPS worker brings the child directly exposed to a drug to the Emergency Department (ED). Children presented to the ED with signs/symptoms of abuse/neglect are assessed and treated by the ED physician and nursing staff. All healthcare workers are mandated to report any suspected abuse to CPS or Adult Protective Services if applicable. The hospital has policies and procedures for identifying and reporting abuse as well as policies and procedures related to the child directly exposed to a drug.
- All cases of suspected child abuse/neglect are reported to DSHS-Division of Child and Family Services.
- Will often do drug screen.
- Toxin exposure evaluation versus assessment for abuse, neglect, developmental/mental health issues.
- No, all DEC children will be screened and treated for exposure/abuse/neglect.
- No, we would call CPS to report any concerns.
- It is difficult to separate the exposure and neglect/abuse as they more often go hand in hand. The response to a child in an acute situation is listed above. Our response to abuse/neglect is to follow the protocols that CPS and law enforcement have for those investigations. If they determine that the abuse/neglect is a result of the parent's drug use, the child then becomes a DEC child and we respond according to our guidelines.

Prosecutor

For the following types of cases (see table below) where drug-endangered children are involved, does the prosecutor's office have formal or informal procedures in place to consider the case's implications for the children and what legal action may best protect their interests?

Procedure / County Size	Does the Prosecutor's Office have a procedure in place to consider drug-endangered children in cases involving the following controlled substances:									
	Meth (child abused or neglected)		**Meth** (child directly exposed)		**Illicit Drugs**		**Alcohol**		**Other drugs** (e.g., prescription drugs)	
Children considered for criminal cases in general										
All	**10 of 22**	**46%**	**11 of 22**	**50%**	**11 of 22**	**50%**	**8 of 22**	**36%**	**10 of 22**	**46%**
Small*	3 of 10	30	4 of 10	40	4 of 10	40	3 of 10	30	3 of 10	30
Medium*	2 of 5	40	2 of 5	40	2 of 5	40	2 of 5	40	2 of 5	40
Large*	5 of 7	71	5 of 7	71	5 of 7	71	3 of 7	43	5 of 7	71
Children considered for cases charged under child endangerment laws										
All	**11 of 22**	**50%**	**11 of 22**	**50%**	**10 of 22**	**46%**	**8 of 22**	**36%**	**10 of 22**	**46%**
Small	4 of 10	40	4 of 10	40	3 of 10	30	3 of 10	30	3 of 10	30
Medium	2 of 5	40	2 of 5	40	2 of 5	40	2 of 5	40	2 of 5	40
Large	5 of 7	71	5 of 7	71	5 of 7	71	3 of 7	43	5 of 7	71
Children considered for cases with possible custody implications										
All	**6 of 22**	**27%**	**6 of 22**	**27%**	**6 of 22**	**27%**	**6 of 22**	**27%**	**6 of 22**	**27%**
Small	2 of 10	20	2 of 10	20	2 of 10	20	2 of 10	20	2 of 10	20
Medium	1 of 5	20	1 of 5	20	1 of 5	20	1 of 5	20	1 of 5	20
Large	3 of 7	43	3 of 7	43	3 of 7	43	3 of 7	43	3 of 7	43

*Caution: Percentages are based on small sample sizes.

If yes for any of the above, please describe how your office considers the interests of the child:

- Criminal cases in general—when children are referenced in the police reports involving controlled substances, we review for criminal charges such as involving a minor. In meth manufacture cases we request testing; however, the timing of the reports and response to such requests may result in missing the window of opportunity for testing. We also contact the Division of Social and Health Services (DSHS). Endangered-children cases are also provided with victim's services and advocacy.
- Criminal filings are required to accurately reflect the criminal conduct committed. Deputy prosecutors then consider aggravating and mitigating factors, which may lead to more serious charges, or simply a higher recommended sentence. Exposure of minors to alcohol or controlled substances in any crime against a person would be an aggravating factor. Obviously, in some cases, the existence of facts showing that a dependent person was exposed to meth creates a different crime.
- Law enforcement training to have children evaluated by CPS and medical professionals. Prosecutor's office considers possible charges related to child endangerment.
- My office works with CPS and the Dependency Court to determine the best placement for the child in terms of safety and well-being. The different agencies share information in order to best prosecute the case as well as preserve evidence.

- Ours is a small county. The prosecutor's office handles all aspects of criminal prosecution as well as Dependent Child actions for DSHS/CPS. Due to this overlap, we must consider the possibility of a child welfare case in every criminal case where children are involved. Also with a very large segment of single parent families, we must consider the ramifications of incarceration of parent on child welfare issues as well.
- Prosecutor's office deputies will often add sentencing enhancement for children present in meth lab sites; child endangerment charges for children directly exposed to drugs with proof in system; and reckless endangerment for children who were at risk of being harmed by exposure to drugs/alcohol. We also charge criminal mistreatment.
- Protocols are currently under development. Office tries to consider children, but is often handicapped, as they may not be mentioned by law enforcement in reports.
- The following factors are considered: 1) has defendant exposed children to drug use or drug preparation? 2) Has defendant endangered children by exposure to persons under the influence of drugs? 3) Was defendant's ability to care for children affected by use of drugs? 4) Is there evidence of abuse or neglect relating to drug use by defendant? 5) Effect of any intervention by CPS.
- We have been working with the local "DEC" group since 2003.
- We have a contract with the Attorney General's office to handle dependencies in […] County.
- We have no written policies, but strive to work closely with CPS for child's welfare.
- What we do is a common-sense approach. Despite the lack of written policies, we certainly take into account the presence of the children in all cases, including drug and alcohol cases.
- When any type of drug case that involves children is referred into our office, the fact that children are involved is flagged in the file. Disposition of the case will then take into account the aggravating factor that children were present or affected by the drug transaction or possession or use. A negotiator may also consider provisions made for the care of the child in determining an appropriate resolution. There is no procedure or policy in place for alerting CPS or other agencies to these cases. The drug unit does not handle cases that specifically deal with alcohol, nor am I aware of any policy in place in the office relating to children endangered by a parent's alcohol abuse. I am also unaware of a procedure or policy in the criminal division that addresses custody issues separately, although the family support unit of our office may address these cases.

Please briefly describe the procedures, formal or informal, that the prosecutor’s office has in place for reviewing evidence from law enforcement, Child Protective Services, and results of biological sample testing to make a determination of what legal action will be taken:

- All cases screened consider all reports from law enforcement, CPS, and chemical screen results. Often, prosecutors will file the appropriate child endangerment charge or sentencing enhancement if a law enforcement officer alleges direct exposure to drugs, despite chemical screen not being available yet (pending).
- All reports are submitted to prosecutor's office to determine what should be charged and the degree to be charged.
- As mentioned above we are not consistently receiving such test results.
- Deputy prosecutors are aware of problems with traditional testing levels and will ensure that appropriate testing was done and request retesting if appropriate.
- If any of above factors are present, other agencies are contacted to ensure coordinated approach to the case.

- If I spent time adopting formal procedures I would never get my job done. I am a working prosecutor; I don't have the luxury of spending time working on protocols. I handle these cases on an ad hoc basis. My reality is that very few reports hit my desk wherein "child" issues and drugs are implicated. I'm not sure how many cases go unreported.
- It is the same for all criminal cases. A review of the information is made to determine if there is sufficient evidence to support a criminal charge. If there is, it is filed. If there is not enough information, it is returned to the investigating agency with a list of things needed to make a case viable. If those things cannot be obtained, no charges are filed.
- Law enforcement trained by literature and training video on how to get children evaluated. Prosecutor's office reviews relevant reports forwarded to our office by drug unit or special assault unit depending on facts.
- My office recently adopted a DEC Investigation Manual (attached) which instructs individuals in the field (such as law enforcement or DSHS) on the gathering and preservation of evidence. All reports are sent to the prosecuting attorney for review and filing of charges. First medical response and hospital emergency room personnel also gather medical information. These individuals are also instructed on the preservation of evidence. Ultimately, all gathered information is sent to the prosecutor for view and determination of filing.
- None as of yet.
- Often the same prosecutor will be involved in both the criminal case and child welfare action. When this is not the case, we have close contact and communication between criminal and child welfare participants. Team meetings and open lines of communication are the rule.
- Procedures involved in DEC cases are handled on a case-by-case basis. Our process involves working very closely with investigating officers, DSHS, and any other agencies depending on the circumstances of the case. We determine what is admissible, the extent of the endangerment, and the impact on the child. Based on the case circumstances, we seek appropriate penalties that hold the adult accountable for endangering the child(ren).
- Reports are screened for charging decisions.
- Reports are submitted by investigating agencies; the reports are date stamped and included in the criminal case report. If police investigation were lacking, we would request follow-up investigatory work that may include additional interviews, forensic measurements and collection of evidence, or laboratory work. Such requests are always in writing, and usually with a deadline. Ordinarily, if we get anything from CPS it comes at our request, although sometimes their reports are included in police investigation reports.
- The office has the practice of handling cases involving children as witnesses or victims more seriously than cases charging the same crime where no child was involved. These practices are formal only in the sense that it is a stated policy in the written filing and disposition standards that govern the handling of each case; there is no separate procedure otherwise involved with respect to children affected by drug crimes. With respect to children who are victims of sexual abuse or assault (i.e., child abuse), there is a far more formal procedure; indeed, we have a separate unit to address these crimes.
- The prosecutor's office works closely with law enforcement and social service partners to screen relevant cases before filing. DEC grant dollars allowed us to do this.
- They are treated just like all other cases. A Deputy Prosecuting Attorney (DPA) is assigned to review the reports for evidentiary sufficiency. The child may be interviewed pre-charging but not necessarily. A supervisor will review any charge or decline decision.

- Upon referral by the investigative agency (law enforcement) for possible criminal charges, the referral is reviewed/screened to determine whether there is sufficient admissible evidence to charge a violation of the criminal code, including alleging statutory enhancements. If a child is involved and endangered or neglected by the alleged criminal activity, law enforcement contacts CPS to coordinate possible removal of the child from the environment.
- We consider all evidence in each case.

Has your prosecutor's office charged any cases under RCW 9A.42.100 (child endangerment by methamphetamine manufacture)?

Number of counties responding "Yes"

All counties	6 of 21	(29%)
Small	0 of 10	
Medium	2 of 4	
Large	4 of 7	

If yes, please describe:

- Any time there is a child present/exposed to a meth lab and we can prove it!
- Children have been found living in a home where meth manufacturing is taking place and where dangerous substances have been within their reach.
- I would make this charging decision if I had sufficient facts.
- Testing has been an issue. We do, however, regularly charge involving a minor in drug dealing.
- That possible charged used as holdback in one case, but defendant pled guilty to original charge.
- We have charged two or three individuals with Endangerment with a Controlled Substance under RCW 9A.42.100. In each case, the defendant was manufacturing meth or permitting meth to be manufactured by others on premises where children were present; and in each case, the child tested positive for meth.
- We have not had any cases recently of manufacture, so the only case was several years ago. At that time neither law enforcement nor this office was aware, so one of the two charged was acquitted and the other case was subsequently dismissed with a plea to the manufacture.

Has your prosecutor's office sought an exceptional sentence or based an increase of the standard range sentence on presence/exposure of children in drug cases?

Percentage of counties responding "Yes"

All counties	9 of 21	(43%)
Small	4 of 10	
Medium	1 of 4	
Large	4 of 7	

If yes, please describe:

- 12-year old present at scene of an active meth lab.
- Charge of involving a minor in the past has been used to obtain exceptional sentence. However, under Blakely case this will likely be reversed on appeal.
- Child present while dealing.

- I would make this charging decision if I had sufficient facts.
- Our office routinely adds sentencing enhancement for kids found in labs. These cases are NOT pled down unless there are extraordinary circumstances.
- School zone enhancements.
- School zone enhancements.
- We could not recall any recent cases where we sought an exceptional sentence for such exposure—we have not had a case like this in recent years.
- We had one case taken federally; and another case, where a child tested positive for meth, is currently pending. However, an increase is being sought.
- We have not sought an exceptional sentence due to the presence or exposure of children in drug cases. The current statutes seem to adequately cover most instances in which children are exposed to drugs. However, we have used the presence of children as a basis to increase our recommendation higher than what it would have been if children were not present, and have refused to reduce cases that might have been reduced (due to factors such as success in treatment) had children not been present or exposed.
- We have used the school zone enhancement occasionally, but not very often. We have increased our standard range recommendation due to the presence of children in a home.

Are there differences between your procedures for meth and your procedures when drugs other than meth are involved?

Number of counties responding "Yes"

All counties	7 of 21 (33%)
Small	4 of 10
Medium	2 of 4
Large	1 of 7

If yes, please describe:

- Meth is prosecuted most aggressively. Other drugs—namely marijuana—there is more movement in plea offers.
- Not written, but meth is seen as more risky than alcohol or marijuana for example—more immediate physical risk of harm anyway.
- PROCEDURES for review and evaluation are same, but STANDARDS are stricter when meth is involved.
- The desire to have testing performed applies to meth. We typically do not seek testing when other substances are involved.
- The procedures are basically the same; however, meth cases generally get close scrutiny and generally warrant more serious enhancements.
- We have a serious and longstanding meth problem in our community. We are well aware of the long-term effects of meth on the user as well as others. We have learned through more than 15 years of meth prevalence about the high relapse rates, psychophysical effects, and potential for violence.

- We respond as a team when manufacturing of meth is involved. CPS seems slightly more concerned when we report meth use by the parents than when we talk about other drugs. We report all cases where there are parents involved with drugs and charged with alcohol and other drug related charges.
- While the procedures are relatively similar, meth cases usually involve more intensity in investigation and collaboration with law enforcement and other agencies, particularly when meth production is involved in the case.
- With the exception that cocaine is generally not manufactured here, while meth is. However, no distinction is made between a house in which meth was found and a house in which cocaine or some other drug was found.

Are there differences between your procedures for prosecuting a case when it is an abuse/neglect issue as opposed to children being directly exposed to drugs (see definition of "drug-endangered children" on first page)?

Number of counties responding "Yes"

All counties	10 of 20 (50%)
Small	3 of 10
Medium	2 of 3
Large	5 of 7

If yes, please describe:

- Abuse/neglect would be referred to our Crimes Against Children Unit, and exposure would likely be reviewed in the drug unit.
- Both are prosecuted aggressively.
- Cases involving children exposed directly to drugs are typically handled by the drug unit, as the children typically need not be witnesses, and the expert witnesses needed are typically those that are routinely used in drug cases. The Special Assault Unit—deputies with greater experience, especially with expert witnesses such as doctors and psychologists, and with training in interviewing children and preparing them for court—handle cases involving the abuse or neglect of children.
- Depends on definition of "exposure."
- Deputy prosecutors assigned to the Child Abuse Intervention Center would have primary responsibility for prosecution of cases involving abuse/neglect. Drug Unit deputy prosecutors would have responsibility for prosecution of cases involving exposure.
- I cannot comment on the differences because our office is divided into units. One unit would prosecute the DEC, while another unit would prosecute for abuse and neglect.
- If there is abuse or neglect, we coordinate with CPS.
- In abuse cases there is more direct involvement. Abuse/neglect cases receive more direct advocacy since the children are often witnesses in the case.
- The case investigation would be different because of the increased need for scientific evidence in the exposure cases. The crimes charged would be different.
- This issue has not come up.
- To the extent Washington law differentiates.
- We will look at the dependency case aspects also.

- While the procedural similarity between abuse/neglect and child exposure cases are about 90 percent the same, the case-by-case differences usually involve more interventions with other social services agencies when abuse/neglect circumstances are present.

STATE OF WASHINGTON
DEPARTMENT OF COMMUNITY, TRADE AND ECONOMIC DEVELOPMENT

Juli Wilkerson, Director

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE

Priscilla Lisicich, Ph.D.
Council Chair